EXHIBIT B

WorkPerks

SOUTHWEST AIRLINES **HEALTH AND WELLNESS**

Southwest Airlines Co. Welfare Benefit Plan
Summary Plan Description
Effective January 1, 2013

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IMPORTANT INFORMATION

KNOW THE VALUE OF YOUR BENEFITS

Southwest's goal is to provide valuable and competitive health care benefits so it is important that every Employee understand the benefit options and how to use them.

- Southwest is **"self-insured"** for medical and dental coverage. Southwest and its Employees actually pay all the bills, not the insurance companies—Southwest, along with your contributions and Copayments, pays for every pill, doctor visit, x-ray, lab work, and hospital visit.
- We encourage all Employees and their Family Members to be smart consumers; You should review your Explanation of Benefit statements as well as your medical invoices as if you were paying these bills yourself.
- **Know what benefits you are enrolled in.** You can see this anytime on **SWALife** >About Me. Read about your benefits and be knowledgeable about how they work.
- **Keep your Family Member eligibility up to date.** Simple things, like removing a former spouse from your benefits or removing children that are no longer eligible, make a huge difference in managing the cost of healthcare for Southwest and You.
- **Keep your home mailing address up to date.** To save on mailing costs, please make sure your address is current. You must update your address via **SWALife**>About Me.

ACKNOWLEDGEMENT, AGREEMENT, AUTHORIZATION, AND RELEASE

• This document is the Southwest Airlines Co. Welfare Benefit Plan Summary Plan Description (SPD). Please make sure You carefully read this SPD, thoughtfully consider Your enrollment options, and understand Your elections.

• By accessing the online enrollment system on **SWALife, You acknowledge that You have read and understand the information about the Plan** including this SPD.

• Your online elections and/or Your utilization of benefits and coverage, whether as a result of Your online elections or Your default elections, constitute **(i) the agreement of You and Your enrolled Family Members to be bound by all of the provisions of the Plan and all applicable laws and (ii) Your authorization for Southwest to reduce Your wages and/or any benefits payable under the Plan** in an amount equal to the required contributions for the benefits You elected (including Your default elections).

• Under BenefitsPlus if You enroll in the Health Care FSA, You are automatically enrolled in the automatic payment option and You authorize the third party administrator to automatically reimburse Your out-of-pocket charges out of Your Health Care FSA during the Plan Year until all funds are exhausted. You will be reimbursed automatically for all allowable charges on claims which are considered, but not fully paid, by Your Medical (but not if You are in the Regular Plan program), Dental, and Vision Programs (processed by the applicable Claims Administrators). **You must terminate the automatic payment option if You would like to use amounts in Your Health Care FSA for charges that are eligible for reimbursement under any other plans or insurance. If claims are reimbursed by both Your Health Care FSA and non-Southwest health insurance coverage, it may have adverse tax consequences for You. You agree to notify the Health & Wellness Team if You or any of Your Family Members has or obtains other coverage during the Plan Year. You release Southwest from any liability that may result from Your failure to terminate the automatic payment option as required.**

Participants, former participants, beneficiaries, and other individuals who are to receive benefits are urged to keep the Plan Administrator advised of current addresses so that benefits can be paid properly. It is your responsibility to notify the Health & Wellness Team in writing if You or Your Family Members have a change in address. Failure to provide this notice may result in ineligibility for benefits.

You and Your Family Members may be eligible for Programs in the Plan including, but not limited to, Medical, Dental, Vision and Life Insurance benefits. The Plan and this SPD provide additional information about these programs. You are required to submit valid proof of eligibility documentation as required when You enroll Your Family Members and at any time additional documentation of verification is requested subsequent to enrollment. Southwest Airlines and its third party administrators may audit benefits eligibility at any time. Falsifying claims, eligibility (including failure to provide required notification of a life event, such as a divorce) or documents may result in Employees or their families receiving benefits for which they are not entitled. Such conduct is unacceptable, may constitute theft, and could result in the denial of claims, loss of coverage, and disciplinary action up to and including termination of employment.

CERTIFICATE OF CREDITABLE COVERAGE

When You lose coverage under the Plan, You will receive a certificate of creditable coverage. This certificate will include information regarding the period of time You were covered under the Plan. You may also request a certificate of coverage from a Claims Administrator within 24 Months of the date You or Your Family Member loses coverage. This certificate may be used to satisfy part or all of a preexisting exclusion period under another health plan or policy.

SUMMARY OF BENEFITS COVERAGE

As an Employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for You and Your family in the case of illness or injury. The Plan offers several health coverage options. Choosing a health coverage option is an important decision. To help You make an informed choice, the Plan makes available a Summary of Benefits and Coverage (SBC) for each option that summarizes important information in a standard format to help You compare across options. The SBCs are available on the online enrollment tool as well as at **SWALife**>About Me>My Benefits>Benefits Information and Resources>Summary of Benefits Coverage. A paper copy is also available, free of charge, by e-mailing **askbenefits@wnco.com** or calling (800) 551-1211.

HEALTH & WELLNESS TEAM

Information about your benefits is available every day on **SWALife** >About Me >Launch About Me Self-Service>My Benefits. You are encouraged to contact the Health & Wellness Team if You have any questions about Your benefits.

Southwest Airlines Co.
Health & Wellness Team
P.O. Box 36611
Dallas, Texas 75235
Toll Free: (800) 551-1211
(214) 792-4997
SDN 792-4997
askbenefits@wnco.com

ADMINISTRATIVE INFORMATION

GENERAL INFORMATION: Contributions to the Plan are made by Southwest and participants depending on the type and level of coverage chosen. Contribution amounts are determined by the Plan Sponsor and communicated to Participants during annual enrollment.

- Except as specified herein with respect to benefits guaranteed by insurance, all benefits paid under the Plan shall be paid from the general assets of Southwest and no person shall have any right, title, or interest whatsoever in or to any investment reserves, accounts, or funds that Southwest may purchase, establish, or accumulate to aid in providing benefits under the Plan. Nothing contained in the Plan, and no action taken under the Plan, shall create a trust or fiduciary relationship of any kind between Southwest and any Employee or any other person, and no current or former Employee, Family Member, beneficiary, or any other person shall acquire any interest greater than that of an unsecured creditor.

EFFECT OF PLAN DOCUMENTS AND INSURANCE CONTRACTS: Your SPD is provided for Your convenience and is intended to give You a summary of the benefits and provisions of the Plan. Although it describes many of the principal features of the Plan, it is only a summary and is subject to the terms and conditions of the Plan document and insurance contracts. If there is inconsistency between the SPD or any other communication regarding the Plan and the Plan documents or insurance contracts, then the Plan documents or insurance contracts will prevail. Copies of the Plan documents and insurance contracts are available upon request from the Health & Wellness Team.

APPLICABLE LAW: To the extent not otherwise preempted by ERISA or federal law, the Plan shall be construed and enforced according to the laws of the State of Texas.

NON-GUARANTEE OF EMPLOYMENT: Neither the Plan nor the SPD, nor Your participation in the Plan is a contract of employment, consideration of employment, or a guarantee of future or continued employment. The Plan does not give You the right to be retained as an Employee. All Employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

NO VESTED BENEFITS: Nothing in the Plan shall be construed as creating any vested rights to benefits or eligibility for participation in favor of any Employee, Family Member, beneficiary, or other person except with respect to claims that have actually been incurred by any such person and that would otherwise be eligible for payment under the terms of the Plan, as in effect at the time the claim or expense was incurred.

NOTICE TO THE PLAN: Except as otherwise specified herein, any notice required to be given under the Plan by a claimant, Employee, Eligible Family Member, beneficiary or a representative of any of the foregoing must be in writing and may be given either by hand delivery to the Plan Administrator or sent by United States mail. If mailed, the date of deposit in the United States mail will be deemed the date on which any such mailed notice is given. **Providing notice to Your department or another Team's knowledge of Your life events (e.g., the Southwest Employees that process retirement benefits, FMLA, workers' compensation, attendance and leave, etc.) does not constitute notice to the Plan, the Plan Administrator, or the Health & Wellness Team.**

AMENDMENT OR TERMINATION: Although Southwest has the bona fide intention and expectation of continuing the Plan, it reserves the right to alter, amend, change, or cancel provisions of the Plan (in whole or in part) or to terminate the Plan in the manner provided by the Plan at any time and for any reason or no reason. Any amendment or termination of the Plan shall become effective on the date specified in the instrument amending or terminating the Plan, which date may be retroactive; provided that no amendment or termination will prejudice any claim under the Plan which was incurred but not paid prior to the date of the amendment or termination. As a matter of prudent business planning, Southwest is continually reviewing and evaluating various proposals for changes in compensation and benefit programs, including the Plan. Some of these proposals, if finally approved and implemented, might be more or less advantageous than the current Plan. Because of the need for confidentiality, such decisions are not discussed or evaluated below the highest level of senior management. Any managers, supervisors, and Employees below such levels do not know whether Southwest will or will not adopt any future compensation and/or benefit programs and are not in a position to speculate about future programs. Unless and until such changes are formally announced by Southwest, no one is authorized to give assurance that such changes will or will not occur. By participating in or receiving benefits under the Plan, You and Your Family Members, and beneficiaries acknowledge that Southwest may adopt new or modified programs or benefits in the future that, depending on individual circumstances, may be more or less advantageous than the current Plan. No person should expect or assume that any such new or modified programs or benefits will be extended on a retroactive basis to any person who is or was eligible for benefits under the Plan.

DISCRETION OF PLAN ADMINISTRATOR: The Plan Administrator shall have the complete and final discretionary authority to administer, operate, and interpret the Plan and to decide any and all matters arising thereunder, including without limitation and with respect to the Plan, the right and authority: to make findings of fact; to determine eligibility for participation, benefits, and other rights under the Plan; to determine whether any election or notice requirement or other administrative procedure under the Plan has been adequately observed; to determine the proper recipient of any Plan benefits; to remedy possible ambiguities, inconsistencies, or omissions by general rule or particular decision; and otherwise to interpret the terms of the Plan. The Plan Administrator's determination on any and all questions arising out of the interpretation or administration of the Plan shall be final, conclusive, and binding on all parties. To the extent the Plan Administrator delegates its fiduciary administrative powers or duties to any other person(s) in writing, including a Claims Administrator, such person(s) shall have the complete discretionary authority, as described in this paragraph, to exercise such powers or duties.

BENEFITS NOT TRANSFERABLE: Benefits under the Plan may not be assigned, transferred, or in any way made over to another party by any person without the written consent of the Plan Administrator. Notwithstanding anything in the Plan to the contrary, the Plan shall not be construed to make Southwest, its affiliates, or the Plan liable to any third-party to whom a participant, Family Member, beneficiary, or other person is liable for care, treatment, services, or otherwise. The interest of any person under the Plan is not subject to the claims of such person's creditors (other than the Plan) and may not be voluntarily or involuntarily transferred, assigned, alienated, pledged, or encumbered (other than to or by the Plan) without the specific written consent of the Plan Administrator.

WAIVER AND ESTOPPEL: No term, condition, or provision of the Plan shall be deemed waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

POWER OF ATTORNEY: To use a power of attorney to authorize another person to act on your behalf with respect to an Employee medical or welfare benefit plan sponsored by Southwest Airlines Co. or any affiliate, including AirTran Airways, Inc. (except for and excluding any insured programs of such plans, including those programs providing life insurance, vision, disability, and accidental death and dismemberment benefits), you must use a power of attorney form approved and provided by the Plan Administrator. To determine if you may use a power of attorney with respect to any insured programs of the Plan, contact the Claims Administrator or Insurance Carrier listed for such benefits in this section of this SPD.

SEVERABILITY: If any provision of any Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. Southwest shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

ADDITIONAL PLAN INFORMATION

OFFICIAL NAME OF THE PLAN: SOUTHWEST AIRLINES CO. WELFARE BENEFIT PLAN

Portions of the Plan are also known as the Medical Program, Dental Program, Vision Program, Flexible Benefits Program, Supplemental Medical and Dental Program for Specified Pilots, Retiree Medical and Dental Program for Specified Pilots, Retiree Health Care Plan For Ramp, Operations, Provisioning and Freight Agents, Noncontract Retiree Health Care Plan, Retiree Health Care Plan for Mechanics, Retiree Health Care Plan for Flight Attendants, Retiree Health Care Plan for Reservation and Customer Service Agents, Southwest Airlines Co. Funded Separation Welfare Benefit Plan, Group Life and Accidental Death and Dismemberment Plan, Long Term Disability Plan, Adoption Assistance Expense Reimbursement Program and Wellness Program.

PLAN NUMBER: 501 **EMPLOYER IDENTIFICATION NUMBER:** 74-1563240

EMPLOYER AND PLAN SPONSOR:
Southwest Airlines Co.
2702 Love Field Dr.
P. O. Box 36611, HDQ-6EB
Dallas, TX 75235
(214) 792-4000

PLAN ADMINISTRATOR:
Southwest Airlines Co. Board of Trustees
c/o Southwest Airlines Co.
2702 Love Field Dr.
P. O. Box 36611, HDQ-6EB
Dallas, TX 75235
(214) 792-4000

AGENT FOR SERVICE OF LEGAL PROCESS: Legal process may be served on the Plan Administrator.

TYPE OF PLAN: Welfare plan providing benefits for medical, dental, prescription, vision, life insurance, AD&D, long term disability coverage, health care and dependent care spending account benefits, adoption assistance expense reimbursement benefits, and wellness programs.

PLAN YEAR: The Plan Year is the Calendar Year (January 1 to December 31).

FUNDING AND INSURANCE: The Plan is funded through general assets of Southwest Airlines Co. and contributions from participants and from investment earnings. The Plan Administrator self-administers benefits under the Adoption Assistance Expense Reimbursement Plan. Adoption assistance expense reimbursement benefits are paid from the general assets of Southwest Airlines Co. Certain programs are insured and administered by Insurance Carriers as listed below.

Life Insurance and AD&D Program
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
(866) 492-6983
Claims (800) 638-6420, #2
Statement of Health (800) 638-6420, #1
www.metlife.com/mybenefits

LTD Program
Cigna (Life Insurance Company of North America)
1601 Chestnut Street
Philadelphia, PA 19192-2235
(800) 732-1603
Claims (888) 873-2127
www.cigna.com

The Vision Program
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
(512) 733-5288
www.eyemedvisioncare.com/swa

COLLECTIVE BARGAINING AGREEMENTS:
Portions of the Plan may be maintained pursuant to one or more collective bargaining agreements between Southwest and the collective bargaining groups listed below. Copies of such agreements may be obtained by written request to the Plan Administrator and are available for inspection during normal business hours.

- Aircraft Mechanics Fraternal Assoc. for the Facilities Maintenance Technicians
- Aircraft Mechanics Fraternal Assoc. for the Mechanics
- Aircraft Mechanics Fraternal Assoc. for the Aircraft Appearance Technicians
- Intl. Brotherhood of Teamsters – Airline Division for the Stock Clerks
- Intl. Brotherhood of Teamsters – Airline Division for the Flight Simulator Technicians
- Transport Workers Union of America Local 556 for the Flight Attendants
- Transport Workers Union of America Local 555 for the Ramp, Operations, Provisioning and Freight Agents
- Southwest Airlines Employees Assoc. for the Flight Dispatchers and Dispatcher Assistants
- Southwest Airlines Pilots' Assoc. for the Pilots
- Southwest Airlines Professional Instructors' Assoc. for the Flight Instructors
- Intl. Assoc. of Machinists and Aerospace Workers for the Customer Service and Customer Representatives

ADMINISTRATION INFORMATION: The Plan is administered by the Plan Administrator and by contract Claims Administrators. The following insurance companies or organizations provide contract claims administration services for the Plan or portions of the Plan and are the Plan's fiduciaries with respect to claims administration with respect to such portions of the Plan identified below. These organizations do not guarantee any Plan benefits under contracts or policies of insurance.

Program	Claims Administrator	Contact Information
Medical	UnitedHealthcare Services, Inc.	P.O. Box 740800 Atlanta, GA 30374-0800 (877) 246-0857 www.myuhc.com
Prescription Drug Choice Plus Plan and Choice Plan C Options	Catamaran	2441 Warrenville Road, Suite 610 Lisle, IL 60532-3642 (800) 451-3101 Specialty Pharmacy (Briova): (855) 427-4682 Mail Order Service: (800) 451-3101
Dental Program	Delta Dental	P.O. Box 1809 Alpharetta, GA 30023-1809 (866) 204-5502 www.deltadentalins.com/southwest
Health Care FSA and Dependent Care FSA	UnitedHealthcare Services, Inc.	P.O. Box 981178 El Paso, TX 79998-1178 (877) 246-0857 www.myuhc.com
Prescription Drug: HSP and Regular Plan	OptumRx	Corporate Office and Customer Services UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 (877) 246-0857 Mail Service P.O. Box 509075 San Diego, CA 92150 www.myuhc.com
Health Savings Account (HSA)	OptumHealth Bank	2525 Lake Park Blvd. Salt Lake City, UT 84120 (800) 791-9361 www.myuhc.com

For all other benefit programs for which claims administration has not been contracted to a third party Claims Administrator (or for certain questions and decisions regarding eligibility, enrollment, or other administrative matters), the Plan Administrator (or its authorized delegate) is the claims administrator.

For second appeals of certain administrative claims and other non-disability and non-group health claims, the Plan Administrator will function as the Claims Administrator for purposes of reviewing adverse benefit determinations on appeal. However, in those circumstances, You will still make all appeals of such to the Health & Wellness Team, who will forward the appropriate second level appeals to the Board of Trustees.

CLAIMS—MEDICAL AND DENTAL PROGRAMS

GENERAL INFORMATION: The procedures for filing claims and receiving payment or benefits under the Medical and Dental Programs, as well as under other benefit programs offered under this Plan, are described at the end of Section 1 of this SPD including detailed procedures regarding the filing of claims, the notice of claims decisions, and the appeals process for any claim denials. The following discussion provides additional information regarding how claims for benefits under the Medical Program and Dental Program are decided.

- An active Employee or active Employee's Family Member age 65 and over who is covered under the Medical and/or Dental Program is entitled to benefits under such Program on the same basis as an active Employee or active Employee's Family Members who is covered and under age 65.

- The charge for a service, supply, treatment, or purchase will be deemed to have been incurred on the date the service or treatment is performed, the supply is provided, or the purchase occurs. The purchase of any items necessary for the treatment of an illness, injury, or condition under the Medical Program or Dental Program will be paid in full if it is determined that the eligible rental cost is greater than the purchase cost.

- Any payment of benefits to a Covered Individual under the Medical Program or Dental Program will be made in accordance with any assignment of rights made by or on behalf of such Covered Individual as required by a state plan for medical assistance approved under Title XIX, §1912(a)(1)(A) of the Social Security Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993); provided, however, that in no event may a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Covered Individual under the Plan. Nevertheless, the fact that an individual is eligible for or is provided medical assistance under the state plan will not be taken into account in determining that individual's eligibility to participate in the Medical Program or Dental Program or the amount of benefits available under the Medical Program or Dental Program.

ALLOWABLE AMOUNT—GENERAL INFORMATION: The Medical Program and the Dental Program cover only charges that the Claims Administrator determines to be Covered Charges and that do not exceed the amount usually charged by most Providers in the same geographic area for services, treatment, materials, or supplies. If the charges are subject to contractual discount arrangements as negotiated by the Plan and In-Network Providers (or some other passive network Provider arrangement), then the Plan will pay at the contracted rate.

- If there are no Providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply, the Claims Administrator will determine the Allowable Amount based on: the complexity involved; the degree of professional skill required; the cost of the services or supplies; and any other pertinent factors.

- Payment of flat rate charges may be declined when procedures, fees, and/or time involved are not itemized.

FILING A CLAIM FOR BENEFITS AND PAYMENT FOR SERVICES: You must submit a Claim Form to the Claims Administrator to request payment of benefits. **Do not send Your Claim Form to Southwest.** If You send Your Claim Form to Southwest, there will be a delay in processing. Claim Forms are available from the Claims Administrator, on SWALife, and on the Claims Administrator's website. Some Providers may file claims for You. You should still obtain an itemized statement from Your Provider for Your records. Even if Your Provider files Your claim for You, You may be required to complete a Claim Form before the Claims Administrator can process the claim.

- If You provide written authorization to allow direct payment to a Provider, all or a portion of any Covered Charges due to a Provider may be paid directly to the Provider instead of being paid to You. The Claims Administrator will not reimburse third parties who have purchased or been assigned benefits by Physicians or other Providers.

EXPLANATION OF BENEFITS (EOB): When a Provider processes at least one claim for Your or a Covered Family Member, You will receive an EOB that provides detailed information about Your claims. You may also track claims online.

Medical Program	www.myuhc.com/uhc
Dental Program	www.deltadental.com/southwest
Vision Program	www.eyemedvisioncare.com/swa

CLAIMS ADMINISTRATOR REVIEW OF CLAIMS: After receipt of a Claim Form, the Claims Administrator will review the claim to determine if the claim is covered under the Plan. The Claims Administrator will notify You if additional information is needed to process the claim. The Claims Administrator may hold Your claim in processing until all required information is received.

- To determine the benefits payable under the Plan, diagnostic aids such as preoperative x-rays and other support documentation may be required. If these aids are not made available, then You may receive no benefit from the Plan or a lesser benefit than the Plan would have paid if the required information had been provided. If a question arises concerning the basis of a claim or a claim payment, the Covered Individual may be required to be examined, at the expense of the Plan Administrator, as often as necessary to resolve the issue.

PAYMENT OF APPROVED CLAIMS: If all or part of Your claim is approved, then Your claim will be paid to the extent benefits are payable.

- If a Covered Individual receives Covered Health Services from an **In-Network Provider**, You are responsible for paying the Deductible and any Copayment/Coinsurance to the In-Network Provider at the time of service or when You receive a bill from the In-Network Provider. For amounts that exceed Your Deductible and Copayment/Coinsurance, In-Network Providers are paid directly for Covered Health Services by the Plan. If an In-Network Provider bills You for any Covered Health Service in excess of Your Deductible and/or Copayment/Coinsurance, contact the Claims Administrator immediately. If the Claims Administrator cannot resolve the issue to Your satisfaction over the phone, then You may submit Your question in writing to the Claims Administrator.

- If a Covered Individual receives Covered Health Services from an **Out-of-Network Provider**, then You are responsible for payment at the time of service and responsible for requesting reimbursement through the Claims Administrator, unless the Out-of-Network Provider is willing to file the claim for You. You and/or the Out-of-Network Provider must file the claim in a format that contains all of the information required as described below. You should file claims for Covered Charges as soon as reasonably possible and in no event later than one Year following the date of service. **If You don't file a claim or provide the required information to the Claims Administrator within this timeframe, then benefits for that Covered Charge will be denied.** If the claim relates to an inpatient stay, then the date of service is the date the inpatient stay ends.

- If You receive services or supplies from an In-Network Provider, You will be responsible for the Deductible and/or Copayment/Coinsurance, and all other payments will go directly to Your Provider. In all other cases (for example, if You receive services or supplies from an Out-of-Network Provider), You will be reimbursed for amounts You paid at the time of service (following Your request for reimbursement) unless the Provider is willing to file the claim for you. If the Provider notifies the Claims Administrator that Your signature is on file assigning benefits directly to the Provider or You make a written request that the Provider be paid directly at the time You submit Your claim, Your Provider will be reimbursed (except for any Deductible and/or Copayment/Coinsurance) to the extent that benefits are payable. Upon making this payment, Southwest, the Plan Administrator, the Claims Administrator, and the Plan is released from any further obligation for the claim payment.

- The Deductible (if any) may be withheld from any Covered Charges and divided among You and any assignees. This claims payment method is legally binding.

DENIAL OF CLAIMS: If all or part of the claim is denied, You will receive written notice from the Claims Administrator which will explain the reason for denial and provide the claim appeal procedures. If You filed the claim improperly or if additional information is needed to process the claim, the notice will describe how to correct the claim or provide the additional information needed. For additional information on appeal procedures, see the section of this SPD that addresses filing appeals.

- Note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between the Covered Individual and his or her Physician; but, note, a health service may or may not be a covered benefit regardless of whether a Physician or the Covered Individual determines that it is needed.

- The Claims Administrators have the exclusive right to interpret and administer the Plan, and the Claims Administrators' decisions are conclusive and binding.

RETURN OF OVERPAYMENT OF CLAIMS: Payment made for charges must be returned to the Plan if it is found that such charges were paid in error. Any unrecovered overpayments will be deducted from any future assigned or unassigned benefits You or Your Family Member would be eligible to receive under the Plan making the overpayment or any other Southwest plan. Furthermore, if a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency who receives or holds such benefit. Such excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding such excess amounts must produce any instruments or papers necessary to ensure this right of recovery.

DEADLINE FOR FILING A LAWSUIT/LIMITATION OF ACTIONS: You cannot bring any legal action against Southwest or the Claims Administrator for any other benefit claim or reason unless You first complete all the steps in the claims procedure process described in this SPD. After completing that process, if You want to bring a legal action against Southwest or the Claims Administrator, You must do so within three Years of the earlier of the date Your employment ends or the date You are notified of the final decision on Your appeal; otherwise You lose any rights to bring such an action against Southwest or the Claims Administrator (except to the extent the provisions of any benefit program provide for a different time frame).

MANDATORY VENUE: Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to this Plan, must be brought in federal court in **Dallas County, Texas**. The federal courts in **Dallas County, Texas** shall have **exclusive jurisdiction** over all disputes arising out of or in any way relating to this Plan.

COORDINATION OF BENEFITS (COB)

GENERAL INFORMATION: All benefits provided under the Medical, Dental, and Vision Programs are subject to a Coordination of Benefits (COB) provision to ensure that two or more plans do not pay the same healthcare charges. If You or Your Family Members are covered under the Plan and Another Group Healthcare Plan, then the plan will pay benefits in accordance with the rules below. The greatest amount of benefits that will be paid after coordinating benefits is 100% of Covered Charges.

- The COB provisions of this section do not apply to (i) coverage of a Family Member as an Employee under any of the Plan's Medical, Dental, or Vision Programs, (ii) individual health insurance coverage, or (iii) state programs which provide benefits for individuals unable to pay for their care.

- The Claims Administrator will require You to provide information from all plans that cover You and Your Family Members. The Claims Administrator may, without Your consent, (i) obtain information from all plans and insurance that cover You and Your Family Members and (ii) give information about You and Your Family Members to other plans and insurance carriers.

- If a payment is made by administrators of other plans that should have been made by the Plan, then the Plan may reprocess the claim or make other arrangements to reimburse the other plans. Any such reprocessed claim or reimbursement will be a benefit paid by the Plan.

- If the Plan overpays benefits, then the Plan has the right to recover overpayments from any (i) Person, (ii) other insurance company, or (iii) other organization to which payments were made.

COB GENERAL RULE: Except when one of the special rules described below apply, the following rules are applied in the following order when determining which plan is primary and pays benefits first and which plan pays second:

1. If Another Group Healthcare Plan does not have a COB provision, then the other group health plan is primary.
2. If a Covered Individual is covered as a current Employee under one plan and as a dependent or former Employee or pursuant to COBRA under another, then the plan that covers the Covered Individual as a current Employee is primary.
3. If a Covered Individual is covered as a dependent of an Employee under one plan and as a former Employee or pursuant to COBRA under another, then the plan covering the Covered Individual as a dependent is primary.
4. If a Covered Individual is covered as a former Employee under one plan and pursuant to COBRA under another, the plan that covers the Covered Individual as a former Employee is primary.
5. In all other cases, the plan that has provided the longest period of continuous coverage to the Covered Individual is primary.

- If You or a Covered Family Member has benefits under the Medical Program in the **Regular Plan option** and Another Group Healthcare Plan, and the Plan pays secondary, then the amount which is paid by the other group plan will be considered a "banked credit" to the extent it would have been paid by the Plan if the Plan were primary. It will be applied to offset necessary Allowable Amount out-of-pocket charges which are covered in whole or in part under Your or Your Covered Family Member's other group plan, but not covered under the Medical Program, and which are incurred by You or Your Covered Family Member during the remainder of the Calendar Year in which the credit is banked. The difference between the cost of a private hospital room and the cost of a Semi-private Room will not be considered reimbursable from the banked credits. No payment by the other plan and the Medical Program will ever exceed 100% of the eligible expense.

COB RULE FOR EXCESS AND AUTO INSURANCE: The Plan is secondary to any excess insurance policy (including, but not limited to, school and/or athletic policies) and to medical payment coverage or personal injury protection (PIP) coverage under any auto liability or no-fault insurance policy. In addition, if the Covered Individual resides in a state where automobile personal injury protection or medical payment coverage is mandatory, then the Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum personal injury protection or medical payment requirement.

COB RULE FOR MEDICARE: To the extent permitted by law, the Plan will be the secondary payor after any payments made by Medicare. Notwithstanding, the plan will pay primary for the following: (i) Covered Individuals who are active Employees covered (other than COBRA coverage) under the Plan; (ii) Covered Family Members of active Employees covered (other than COBRA coverage) under the Plan; and (iii) Covered Individuals who are active Employees or Covered Family Members of active Employees covered (other than COBRA coverage) under the Plan and who are receiving Medicare Part A due to a permanent and total disability.

- If a Covered Individual is eligible for Medicare coverage due to end stage renal disease ("ESRD"), the Plan will provide coverage on a primary basis or secondary basis as required by applicable law. If the Plan is required to provide primary coverage for the first 30 Months of ESRD Medicare eligibility, then this 30 Month ESRD coordination period starts from the date the Covered Individual becomes eligible for Medicare, not from the date of Medicare entitlement.

COB RULE FOR DEPENDENT CHILDREN: If Your dependent children are covered under both You and Your Spouse's health plan, the determination of which plan is primary and pays benefits first and which plan pays second for the dependent children's charges will be applied in the following order:

1. If Another Group Healthcare Plan does not have a COB provision, then the other group health plan is primary.
2. The plan of the parent with a birthday earliest in the Calendar Year is primary.
3. If both parents have the same birthday, the plan which covered the parent for the longer period of time is primary.

▪ If the natural parents of a dependent child are divorced or legally separated, then the determination of which plan is primary and pays benefits first and which plan pays second for the dependent children's charges will be applied in the following order:

1. If Another Group Healthcare Plan does not have a COB provision, then the other group health plan is primary and pays benefits first.
2. If a court decree establishes financial responsibility for medical coverage or other health care costs of the child, then the plan of the parent with court ordered financial responsibility is primary and pays benefits before all other plans that cover the child.
3. If the parent with custody of the child has not remarried, then the plan of the parent with custody of the child is primary.
4. If the parent with custody of the child has remarried, then the plan of the parent with custody of the child is primary. The plan of the stepparent of the child is secondary. The plan of the parent without custody of the child pays last.
5. If all the situations or rules above relating to dependent coordination of benefits are not applicable, then the plan that has covered the child for the longest continuous period is primary.

ACTS OF THIRD PARTIES—RIGHTS OF RECOVERY

GENERAL INFORMATION: This provision (Acts of Third Parties—Rights of Recovery) applies when one or more of the Medical and/or Dental Programs (each is individually referred to in this section as a "Subrogating Plan") pays claims for the treatment of an illness, injury, or condition for which a Third Party is, or may be held, liable or legally responsible (for example, when a Subrogating Plan pays claims for the treatment of an illness, injury or condition caused by an automobile accident or another's negligence). A Third Party may include, but will not be limited to, any one or more of the following: (i) the party or parties who caused the illness, injury, or condition; (ii) the insurer, guarantor, or other indemnifier of the party or parties who caused the illness, injury, or condition; (iii) the Covered Individual's own insurer (for example, uninsured, underinsured, and no fault coverage); (iv) a worker's compensation insurer; and/or (v) any other person, entity, policy, healthcare plan or insurer that is liable or legally responsible in relation to the illness, injury, or condition. References below to a Covered Individual include the estate or other legal representative of the Covered Individual.

CONDITIONAL BENEFIT PAYMENTS: Any such benefits paid by a Subrogating Plan are conditioned upon and subject to an equitable lien requiring actual repayment to the Subrogating Plan. Such conditional benefits will be subject to a constructive trust for the benefit of the Subrogating Plan in the event the Subrogating Plan is entitled to reimbursement or subrogation as described below. Furthermore, if the Subrogating Plan is entitled to reimbursement or subrogation and the Covered Individual fails to comply with all of the reasonable requirements of the Subrogating Plan for receipt of benefits, including cooperation with the Subrogating Plan's rights of reimbursement and subrogation, the Subrogating Plan will be entitled to restitution of any conditional benefits wrongfully paid or provided to or for the benefit of the Covered Individual. The Subrogating Plan may require that such conditional benefits be held in escrow or trust (subject to the Plan's rights of reimbursement and subrogation) until a final determination is made regarding the Subrogating Plan's right to payments made by the third party or liability or responsibility of the Third Party for the illness, injury, or condition.

LIEN: The Subrogating Plan will have a first priority lien against, and will be entitled to recovery of, the first dollars paid or payable by any Third Party (including but not limited to insurers) with respect to an illness, injury, or condition of the Covered Individual for which such Third Party is, or may be held, liable or legally responsible, regardless of whether such amounts are paid pursuant to a legal judgment, arbitration award, compromise, settlement or any other arrangement and regardless of how the claims, awards, recoveries or amounts paid or payable are classified or characterized by the parties, the courts or any other person or entity, including, for example, amounts paid to or for the benefit of the Covered Individual for general damages, and regardless of whether the Covered Individual is made whole for his claim for benefits by the recovery against which the Subrogating Plan may assert its rights hereunder. The amount of such lien will equal the lesser of: (i) the amount of benefits paid by the Subrogating Plan for the illness, injury, or condition plus the amount of all future benefits which may become payable under the Subrogating Plan due to the illness, injury, or condition, or (ii) the amount recoverable from the Third Party.

REIMBURSEMENT FROM THIRD PARTY RECOVERIES: As consideration for the payment of benefits under the Subrogating Plan prior to the receipt of payment from a Third Party, the Covered Individual agrees to repay the Subrogating Plan first from any money or other benefit recovered by the Covered Individual from the Third Party who is, or may be held to be, liable or legally responsible for the illness, injury, or condition giving rise to the paid benefits. The obligation to repay applies (i) whether the payment received from the Third Party is the result of a legal judgment, arbitration award, compromise, settlement, or any other arrangement, (ii) regardless of whether the Third Party has admitted liability for the payment, (iii) regardless of whether the charges are itemized in the Third Party's payment or whether the Third Party's payment is structured as a settlement for pain and suffering or in any other manner which does not itemize charges, and (iv) regardless of whether the Covered Individual has incurred, or agreed to pay, any costs or charges in relation to securing the recovery from the Third Party. The Covered Individual may be required at any time to confirm such agreement in writing. If the Covered Individual fails to sign

any such required agreement, any claims for benefits will be pended until the agreement is signed. The Subrogating Plan will not pay or be subject to offset of any recovery or in any way be responsible for any fees or costs associated with pursuing a claim against any Third Party unless the Plan agrees to do so in writing.

If such a recovery is made and the Subrogating Plan is not reimbursed as required herein, then the Covered Individual (and his or her estate or other legal representative) will be personally liable to the Subrogating Plan for the amount of the benefits paid under the Subrogating Plan for such illness, injury, or condition. The Subrogating Plan will be reimbursed for the total value of the claim for benefits paid by the Subrogating Plan with respect to such illness, injury, or condition, plus the Subrogating Plan's reasonable attorney's fees and other costs of collection, if any, but such aggregate reimbursement amount will not exceed the total amount payable to or on behalf of the Covered Individual from (i) any policy or contract from any insurance company or carrier (including, without limitation, the Covered Individual's insurer) and/or (ii) any Third Party, plan or fund as a result of a legal judgment, arbitration award, compromise, settlement or any other arrangement. In addition, the Subrogating Plan may recover interest at the rate of one and one-half percent (1½%) per Month or the maximum amount permitted by applicable law, whichever is less, commencing on the date the Covered Individual recovers any such funds from a Third Party. Reimbursement may be made by any method satisfactory to the Subrogating Plan. If repayment is not made, the Plan may reduce future benefits that would otherwise be payable for any illness, injury or condition of the Covered Individual up to the amount of the payment that was received from the Third Party.

Once a Covered Individual has received payment, in whole or in part, from the Third Party, future charges incurred and related to such illness, injury, or condition will not thereafter be reimbursable from, or paid directly by, the Plan, except as may be provided otherwise in a separate written agreement signed by the Covered Individual and the Subrogating Plan which makes adequate provision for the satisfaction of the Subrogating Plan's reimbursement claim. Funds paid or payable by Third Parties for future medical claims relating to the same illness, injury, or condition of a Covered Individual for which a Third Party is, or may be held, liable or legally responsible will be set aside, in an escrow account, for the benefit of the Covered Individual. The Subrogating Plan may require that any portion of the amount held in trust or escrow be turned over to the Subrogating Plan upon submission to the Covered Individual of proof of benefit payment by the Subrogating Plan.

SUBROGATION OF RIGHTS AGAINST THIRD PARTIES: As a condition to receiving benefits under the Subrogating Plan, each Covered Individual transfers to the Subrogating Plan such Covered Individual's (and his or her representative's) rights to take legal action against Third Parties arising from any illness, injury, or condition for which such Third Parties are, or may be held, liable or legally responsible. Upon paying or providing any such benefits, the Subrogating Plan will immediately be subrogated to and succeed to all of the Covered Individual's claims, demands, actions and rights of recovery (under all possible legal theories) against any entity including, but not limited to, Third Parties and insurance companies and carriers (including the Covered Individual's insurer). That is, the Subrogating Plan may take over the Covered Individual's right to receive payments from the Third Party to the extent of the benefits paid or payable plus the Subrogating Plan's reasonable costs of collection. It will only be necessary that the illness, injury, or condition occurred through the act of a Third Party for the right to recover damages to inure to the Subrogating Plan.

As further consideration for the payment of benefits under the Subrogating Plan prior to the receipt of payment from a Third Party, the Covered Individual agrees to cooperate fully in asserting the Subrogating Plan's subrogation and recovery rights against the Third Party. The Covered Individual or his or her legal representative will, within 5 days of receiving a request from the Subrogating Plan, provide all information and sign and return all documents necessary to exercise the Subrogating Plan's rights under this provision.

OTHER PROVISIONS:

By accepting benefits under the Subrogating Plan, the Covered Individual acknowledges that attached to the receipt of those benefits is the obligation to abide by the terms of this provision, that failure to abide by the terms of this provision constitutes wrongdoing and that in such case, the initial receipt of benefits was, therefore, ill gotten. Failure by a Covered Individual to abide by the terms of this provision will result in immediate termination of coverage of the Employee or former Employee to whom the Covered Individual's coverage is attributable and all of his or her Covered Family Members.

The Covered Individual will cooperate in assisting the Subrogating Plan in protecting the Plan's rights to reimbursement and subrogation and will not act or fail to act at any time or in any manner that prejudices the Subrogating Plan's rights under this provision (including settling a claim with a Third Party without advance notice to the Subrogating Plan).

The Subrogating Plan's rights to reimbursement and subrogation, and any recovery pursuant to those rights will not be reduced: due to the Covered Individual's own negligence; or due to the Covered Individual's not being made whole; or by any portion of a Covered Individual's attorney's fees and costs. No equitable claims or defenses of any kind shall apply to the Subrogating Plan's right to reimbursement and subrogation, and any recovery pursuant to these rights, including but not limited to offset, detrimental reliance, equitable and promissory estoppel, the "make whole" doctrine, and the "common fund" doctrine.

The Subrogating Plan has the right to recover interest at the rate of one and one-half percent (1½%) per Month or the maximum amount permitted by applicable law, whichever is less, commencing on the date the Covered Individual or his or her legal representative recovers any funds from a Third Party. The Subrogating Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Subrogating Plan is secondary to any excess insurance policy including, but not limited to, school and/or athletic policies.

If the Covered Individual resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary, and the Subrogating Plan takes secondary status. The Subrogating Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum personal injury protection or medical payment requirement.

This provision also applies to any funds recovered from the Third Party by or on behalf of: (i) a minor Covered Individual; (ii) the estate of any Covered Individual; and (iii) any incapacitated person.

CLAIMS PROCEDURES AND APPEALS

IN GENERAL: The Plan Administrator (including, for all purposes in this Claims Procedures section, any other person or entity with respect to whom claims administration for the Plan has been delegated, hereinafter referred to as the "Claims Administrator") has established benefit claims procedures under the Plan. The following claims procedures set forth the rules relating to (1) submission of claims for benefits, (2) the processing of claims for benefits, (3) notification to claimants of the disposition of claims for benefits, (4) the procedural requirements for a claimant to obtain an appeal of a denied or modified claim, (5) the processing of appeals of denied or modified claims, and (6) if applicable, the external review of claims that were denied or modified on appeal. The claims procedures applicable to any given claim vary depending upon whether the claim is for group health plan benefits, disability benefits, or other benefits that are non-disability and non-group health plan benefits. Accordingly, these claims procedures are divided into three sections to address each of these three groups of claims. Any claim for benefits under any benefit program that is not subject to ERISA, or any claim that relates solely to eligibility or administrative questions and not to the payment of benefits, will be deemed to be a non-disability claim under a benefit program that is not a "Group Health Plan" for purposes of these claims procedures.

In connection with the submission of any claim, the claimant (i.e., You or Your Covered Family Member) may (1) examine the Plan and any other relevant documents relating to the claim, (2) submit written comments relating to the claim, and (3) have an authorized representative act on behalf of the claimant. (The word "You in this section of the SPD refers to You, Your Covered Family Member, and any authorized representative of You or Your Covered Family Member). All claims and appeals will be processed in accordance with the governing Plan documents, and Plan provisions will be applied on a consistent basis with respect to similarly situated persons.

NOTE: For all claims for benefits under the Plan, if You or any other person entitled to benefits under the Plan does not comply with the Plan's claims review procedures, or does not do so in a timely manner, You or such person will have failed to exhaust the administrative remedies under the Plan and may not commence any legal or equitable action claiming benefits under the Plan.

CLAIMS REVIEW PROCEDURE FOR GROUP HEALTH PLANS: These claims review procedures apply to claims for benefits under any Program that is a "group health plan," including the Medical Program, Dental Program, Vision Program, and Health Care FSA Program. For claims under these Programs, different procedures apply for Urgent Care Claims, Pre-Service Claims, and Post-Service Claims, as each is described below. In addition, as indicated below, additional procedures apply for the Medical Program options that are not "grandfathered" for purposes of the Patient Protection and Affordable Care Act ("Non-Grandfathered Medical Program options"). The Regular Plan Benefit Program is the only group health plan program offered that is not a Non-Grandfathered Medical Program. Regardless of which type of claim or program is involved, to obtain payment of any benefits under these programs, You must file a claim for benefits within 12 Months of the date in which the Eligible Charges were incurred.

- **Urgent Care Claims:** An "Urgent Care Claim" is any claim for medical care or treatment where the application of the time periods normally applicable to benefit claims could seriously jeopardize the patient's life, health, or ability to regain maximum function, or would subject the patient to severe pain that cannot be adequately managed without the urgent care or treatment that is the subject of the claim. Urgent Care Claims should be filed with the Claims Administrator. The Claims Administrator will provide notice of the decision on the claim as soon as possible taking into account the medical exigencies of the situation but no later than 72 hours after receipt of the claim. However, if You are currently undergoing treatment for a condition and seek to extend that course of treatment beyond the pre-approved period of time or number of treatments and such extension involves urgent care (i.e., a "concurrent claim"), notice of the decision must be given within 24 hours after the concurrent claim is filed, if the concurrent claim is filed at least 24 hours before the end of original course of treatment. If the concurrent claim is not filed within this 24-hour period, the normal 72-hour rule will apply.
If the Claims Administrator subsequently decides to reduce or terminate a previously approved ongoing course of medical treatment, the Claims Administrator will notify You of such action at a time sufficiently in advance of the reduction or termination to allow You to file a claim and obtain a determination on Your claim before the benefit is reduced or terminated.

If an Urgent Care Claim is improperly filed or if additional information is required to decide the Urgent Care Claim, the Claims Administrator will notify You within 24 hours of receipt of such claim. You will then have 48 hours to provide the additional information requested. The additional information may be provided by telephone, facsimile, or any other available similarly expeditious method. Notice of the decision on the claim will be given as soon as possible but not later than 48 hours after the

earlier of the Claim Administrator's receipt of the requested information or the end of the 48-hour period afforded to You to provide the requested information.

- **Pre-Service Claims:** A "Pre-Service Claim" is any claim for medical care or treatment that requires advance approval (i.e., pre-certification) in order for benefits to be payable under a group health plan and is not an Urgent Care Claim. Pre-Service Claims should be filed with the Claims Administrator. The Claims Administrator will provide notice of the decision on such a claim within a reasonable period of time corresponding with Your medical circumstances, but no later than 15 days after the Claims Administrator receives the claim, unless special circumstances require an extension of time to review the claim and You are notified in advance of the need for an extension, in which case the decision will be made within 30 days after the claim is filed. If the extension is due to the need for additional information necessary to decide the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide the additional information requested. The deadline for the Claims Administrator's notice of decision on the claim will be suspended from the date the Claims Administrator sends You the notice of extension to the earlier to occur of (i) the date the Claims Administrator receives the requested information or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You do not provide the requested information by the end of the 45-day period afforded to You, the Claims Administrator will decide the claim without regard to the requested information.

- **Post-Service Claims:** A "Post-Service Claim" is any claim for medical care or treatment which is not an Urgent Care Claim or a Pre-Service Claim. Post-Service Claims should be filed with the Claims Administrator. The Claims Administrator will provide notice of the decision denying or modifying the claim within 30 days after the claim is filed, unless special circumstances require an extension of time to review the claim and You are notified in advance of the need for an extension, in which case the decision will be made within 45 days after the claim is filed. If the extension is due to the need for additional information necessary to decide the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide the additional information requested. The deadline for the Claims Administrator's notice of decision on the claim will be suspended from the date the Claims Administrator sends You the notice of extension to the earlier to occur of (i) the date the Claims Administrator receives the requested information or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You do not provide the requested information by the end of the 45-day period afforded to You, the Claims Administrator will decide the claim without regard to the requested information.

- **Notice of Initial Decision of Claims Administrator:** The Claims Administrator will notify You, in the case of an Urgent Care Claim or a Pre-Service Claim, of its decision, and, in the case of a Post-Service Claim, of an adverse decision, regarding Your claim. The notice will be provided to You in writing, except that a notice in connection with an Urgent Care Claim may be given to You orally if written notification is given to You within three days after the oral notification. If Your claim is denied, the notice provided to You by the Claims Administrator will state: (i) the specific reason or reasons why the claim was denied; (ii) the specific Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary; (iv) a description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of Your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; however, the notice will advise that Your right to bring a civil action under section 502(a) of ERISA follows Your final appeal (except in the case of an Urgent Care Claim, for which only one appeal is permitted); (v) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or criterion, or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the benefit determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge to You upon request; (vi) if the claim is denied based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You free of charge; and (vii) if an Urgent Care Claim is involved, a description of the expedited review procedure available for such claims. In addition, if the claim is a claim for Non-Grandfathered Medical Program option benefits, the notice will also state: (i) the denial code and its corresponding meaning; (ii) a description of the Plan's standard, if any, that was used in denying the claim; (iii) information sufficient to identify the claim involved, including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code (and its corresponding meaning) and the treatment code (and its corresponding meaning); and (iv) information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable law to assist individuals with the internal claims and appeals and external review processes.

RIGHTS ON APPEAL:

- **To appeal the denial or modification of an Urgent Care Claim,** You must submit a request for review to the Claims Administrator as soon as practicable based on the medical exigencies of the situation involved but no later than 180 days after You receive the notice of the denial or modification. You may request, orally or in writing, an expedited review process under which You may file Your appeal by telephone, in person, or in writing, and all necessary information, including the decision on Your appeal, will be transmitted by telephone, facsimile, or any other available similarly expeditious method. The Claims Administrator will provide You notice of its decision on Your appeal as soon as possible taking into account the medical exigencies of the situation but no later than 72 hours after Your request for review is received by the Claims Administrator.

▪ **To appeal a denial or modification of a Pre-Service Claim or a Post-Service Claim,** You must submit a written request for review to the Claims Administrator within 180 days after receiving the notice of the denial or modification. The Claims Administrator will provide You notice of its decision (i) for a Pre-Service Claim appeal within 15 days after such appeal is filed and (ii) for a Post-Service Claim within 30 days after such appeal is filed.

▪ If You appeal the denial of Your benefit claim, then, in connection with Your appeal, You will be provided the opportunity to submit written comments, documents, records, and other information relating to Your claim for benefits, all of which information will be taken into account in deciding the appeal. In addition, You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for benefits, and the Claims Administrator will identify the medical or vocational expert(s) whose advice was obtained on behalf of the Plan in connection with the denial of Your initial benefit claim, regardless of whether such advice was relied upon. In making a benefit determination on appeal, the Claims Administrator will not give deference to the initial adverse benefit determination or, if applicable, in the first appeal.

▪ The determination on appeal will be made by a named fiduciary of the Plan who is neither an individual who made a prior adverse benefit determination in connection with the claim nor a subordinate of such individual. In the case of any appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the Claims Administrator's review of Your appeal will be based on its consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such professional will not be an individual who was consulted in connection with the original denial of Your benefit (or, if applicable, the first appeal) or a subordinate of that individual. In addition, with respect to claims for Non-Grandfathered Medical Program options, the following additional review procedures will apply to the extent required by law: (i) You will be allowed to review the claim file and, as appropriate, present evidence and testimony; (ii) if new or additional evidence is considered or relied on (which was not considered or relied on in the earlier decision), You will be provided notice of this new evidence free of charge; and (iii) before a final internal denial is made based on a new or additional rationale, You will be provided advance notice of this new or additional rationale free of charge.

▪ **The Claims Administrator will notify You of its benefit determination on appeal** in writing unless You request otherwise pursuant to an expedited review process for an Urgent Care Claim. If the appeal is denied, the notice will state: (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to Your claim for benefits; (iv) a statement describing Your right to bring suit under section 502(a) of ERISA following the appeal of an adverse benefit determination; however, if applicable, the notice will advise You that You have the right to bring a second appeal to the Claims Administrator and that Your right to bring a civil action under section 502(a) of ERISA follows Your final appeal (except in the case of an Urgent Care Claim, for which only one appeal is permitted); (v) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or criterion or a statement that such rule, guideline, protocol, or criterion will be provided to You free of charge upon request; (vi) if the adverse benefit determination is based on a medical necessity or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances or a statement that such explanation will be provided free of charge upon request; and (vii) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your area U.S. Department of Labor Office and your State insurance regulatory agency." In addition, if the claim is a claim for Non-Grandfathered Medical Program option benefits, the notice will also state: (i) the denial code and its corresponding meaning; (ii) a description of the Plan's standard, if any, that was used in denying the claim; (iii) information sufficient to identify the claim involved, including the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code (and its corresponding meaning) and the treatment code (and its corresponding meaning); and (iv)information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable law to assist individuals with the internal claims and appeals and external review processes.

▪ **If the Claims Administrator denies Your Pre-Service Claim on appeal, under certain benefit programs as described above, or your Post-Service Claim on appeal, You have the right to make a second appeal to the Claims Administrator** within 180 days after Your receipt of the initial denial by the Claims Administrator (but, if later, until 60 days after notice to You of the Claim's Administrator's decision on Your first appeal). The Claims Administrator will provide You notice of its decision on Your second appeal decision (i) for a Pre-Service Claim appeal within 15 days after such second appeal is filed and (ii) for a Post-Service Claim within 30 days after such second appeal is filed.

▪ **Notification of Proper Procedure:** If You improperly file a claim for medical care or treatment that requires advance approval (*i.e.*, pre-authorization) in order for benefits to be payable under the applicable benefit program but You have provided a communication to a person customarily responsible for handling benefit matters that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, the Claims Administrator will notify You of the failure to properly file and of the proper procedures for filing such a claim. The Claims Administrator will provide the notification within five days (24 hours in the case of an Urgent Care Claim) after receipt of the improperly filed claim, and the notification may be oral, unless You request written notification.

EXTERNAL REVIEW PROCESS FOR NON-GRANDFATHERED MEDICAL PROGRAM OPTIONS: If Your claim for Non-Grandfathered Medical Program option benefits is denied after all applicable internal appeals, You may request an external review of the denial. The following is a brief summary of the external review process. Please contact the applicable Claims Administrator for additional details.

- **Deadline for request:** A request for external review must be filed within four Months after You receive the notice of denial on appeal, in accordance with the procedures established by the appropriate Claims Administrator.

- **Eligibility for external review:** Denial of claims based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit are generally eligible for external review. Please contact the applicable Claims Administrator for additional details about which claims are eligible for external review.

- **External Review Process:** After filing a request, You will be notified whether Your claim is eligible for external review. If eligible, You will receive a notice that Your claim has been assigned to an independent review organization ("IRO") and be given the opportunity to submit additional information for the IRO to consider. In reaching a decision, the IRO will not be bound by any decision or conclusion reached by the applicable Claims Administrator. The IRO will provide a written notice of its decision within 45 days after it is assigned Your claim.

- **Expedited External Review Process:** Under certain circumstances (e.g., medical conditions for which the standard external review timeframe would seriously jeopardize the claimant's life or health), You may request an expedited external review. Please contact the applicable Claims Administrator for additional details.

CLAIMS REVIEW PROCEDURE FOR DISABILITY BENEFIT CLAIMS: In the event the Claims Administrator denies or modifies Your claim for benefits under the Program that provides disability benefits, You will be notified in writing within 45 days of the date such claim is received by the Claims Administrator (except that the Claims Administrator may twice extend the deadline for 30-day periods, in which case You will be notified in writing prior to any deadline extension of the date of and reason for the extended deadline). If the Claims Administrator requires an extension because it needs more information from You to review the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide such information. The Claims Administrator's deadline to notify You of a denial or modification will be postponed until the earlier of (i) the date You respond or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You fail to provide the requested information by the expiration of the 45-day period afforded to You, the benefit determination will be made without regard to the requested information. Notification of a denial or modification will include the following: (i) the specific reason for the denial or modification; (ii) the Plan or benefit program provisions upon which the denial or modification is based; (iii) any additional material or information necessary to perfect Your claim and the reasons why such material or information is necessary; (iv) the Plan's claim review procedure, including the right to bring a civil action under ERISA; (v) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial or modification, either the criterion or a statement that such criterion was relied upon in making the denial or modification and that a copy will be provided free of charge to You upon request; and (vi) if the denial or modification is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan or benefit program to Your medical circumstances, or a statement that such explanation will be provided free of charge to You upon request.

In the event Your claim is denied or modified and You want a review of this initial decision, You must, within 180 days following receipt of the denial or modification, submit a written request to the Claims Administrator for review of its initial decision. In connection with a review of the Claim Administrator's initial decision: (i) You will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) the person who conducts the claim review will not have participated in the initial benefit determination and will not be a subordinate of anyone who participated in the initial benefit determination; (iii) You are entitled to access or copy any information free of charge that was submitted, considered, or generated during the initial review or that demonstrates compliance with administrative processes and safeguards designed to ensure consistency and compliance with the Plan and/or the benefit program; (iv) the Claims Administrator will consider all issues and comments submitted for review; (v) he Claims Administrator will identify any medical or vocational experts whose advice was obtained in connection with the initial benefit determination; (vi) he review will not afford deference to the initial claim determination; and (vii) if the initial claim was denied or modified based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the claim review will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not, and is not the subordinate of someone who was, consulted in connection with the initial claim determination.

Within 45 days following the request for review, the Claims Administrator will, after a full and fair review, render its decision on appeal in writing to You stating specific reasons for its decision (except that the Claims Administrator may extend the deadline for an additional 45-day period, in which case You will be notified in writing prior to the deadline extension of the date of and reason for the extended deadline). If the Claims Administrator requires an extension because it needs more information from You to review the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide the requested information. The Claims Administrator's deadline will be suspended from the date the Claims Administrator sends the notice of extension to the earlier of (i) the date the Claims Administrator receives the requested information or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You do not provide the requested information by the expiration of such 45-day period, the benefit determination will be made without regard to the requested information. Notification of an adverse determination on review will include the following: (i)

the specific reason for the adverse determination; (ii) the Plan and benefit program provisions upon which the adverse determination is based; (iii) a statement that You are entitled to receive free of charge access to and copies of any information that was submitted, considered, or generated in the course of making the benefit determination or that demonstrates compliance with administrative processes and safeguards designed to ensure consistency and compliance with the Plan and benefit program; (iv) a statement of Your right to bring a civil action under ERISA following the appeal of an adverse benefit determination; (v) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the criterion or a statement that such criterion was relied upon in making the adverse determination and that a copy will be provided free of charge to You upon request; (vi) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan and applicable benefit program to Your medical circumstances, or a statement that such explanation will be provided free of charge to You upon request; and (vii) the statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

CLAIMS REVIEW PROCEDURE FOR NON-DISABILITY BENEFIT CLAIMS UNDER PLANS THAT ARE NOT GROUP HEALTH PLANS: In the event the Claims Administrator denies or modifies Your claim for non-disability benefits under a Plan benefit program that is not a group health plan, You will be notified in writing within 90 days of the date such claim is received by the Claims Administrator (except that the Claims Administrator may extend the deadline for an additional 90-day period, in which case You will be notified in writing prior to any deadline extension of the date of and reason for the extended deadline). If the Claims Administrator requires an extension because it needs more information from You to review the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide the requested information. The Claims Administrator's deadline will be suspended from the date the Claims Administrator sends the notice of extension to the earlier of (i) the date the Claims Administrator receives the requested information or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You do not provide the requested information by the expiration of such 45-day period, the benefit determination will be made without regard to the requested information.

If the Claims Administrator denies Your claim on appeal, You have the right with respect to certain claims (e.g., any claim that is not a disability claim and not under a group health plan, except for claims for benefits under the Life Insurance and Accidental Death and Dismemberment Programs) to make a second appeal to the Claims Administrator within 180 days after Your receipt of the initial denial (but, if later, until 60 days after notice to You of the Claim's Administrator's decision on Your first appeal). The Claims Administrator will provide You notice of its decision on Your second appeal within 45 days after Your second appeal is filed. Notification of a denial or modification will include the following: (i) the specific reason for the denial or modification; (ii) the Plan provisions upon which the denial or modification is based; (iii) any additional material or information necessary to perfect Your claim and the reasons why such material or information is necessary; and (iv) the Plan's claim review procedure, including the right to bring a civil action under ERISA.

In the event Your claim is denied or modified and You want a review of this initial decision, You must, within 60 days following receipt of the denial or modification, submit a written request to the Claims Administrator for review of its initial decision. In connection with a review of the Claims Administrator's initial decision: (i) You will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) You are entitled to access or copy any information free of charge that was submitted, considered, or generated during the initial review or that demonstrates compliance with administrative processes and safeguards designed to ensure consistency and compliance with the Plan and the relevant benefit program; and (iii) the Claims Administrator will consider all issues and comments submitted for review.

Within 60 days following the request for review, the Claims Administrator will, after a full and fair review, render its decision on appeal in writing to You stating specific reasons for its decision (except that the Claims Administrator may extend the deadline for an additional 60-day period, in which case You will be notified in writing prior to any deadline extension of the date of and reason for the extended deadline). If the Claims Administrator requires an extension because it needs more information from You to review the claim, the notice of extension provided to You will describe the required information, and You will have 45 days to provide the requested information. The Claims Administrator's deadline will be suspended from the date the Claims Administrator sends the notice of extension to the earlier of (i) the date the Claims Administrator receives the requested information or (ii) the expiration of the 45-day period afforded to You to provide the requested information. If You do not provide the requested information by the expiration of such 45-day period, the benefit determination will be made without regard to the requested information.

Note, however, that with respect to any second appeal that is reviewed by the Southwest Airlines Co. Board of Trustees, functioning as the Claims Administrator with respect to such appeal, the time frames described in the previous paragraph will not apply, and instead, the Board of Trustees shall make its benefit determination on appeal no later than the date of the meeting of the Board of Trustees that immediately follows the Claims Administrator's receipt of the second appeal, unless the request for appeal is filed within 30 days preceding the date of such meeting, in which case, the benefit determination on appeal may be made by no later than the date of the second meeting of the Board of Trustee's following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board of Trustees' benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the Claims Administrator's receipt of the request for review. If such an extension of time for review is required, the Claims Administrator shall provide You with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Claims Administrator shall notify You of

the benefit determination as soon as possible but no later than 5 days after the determination is made. Notification of an adverse determination on review will include the following: (i) the specific reason for the adverse determination; (ii) the Plan or relevant benefit program provisions upon which the adverse determination is based; (iii) a statement that You are entitled to receive free of charge access to and copies of any information that was submitted, considered, or generated in the course of making the benefit determination or that demonstrates compliance with administrative processes and safeguards designed to ensure consistency and compliance with the Plan and relevant benefit program; and (iv) a statement of Your right to bring a civil action under ERISA following the appeal of an adverse benefit determination[; however the notice will advise You that You have the right to bring a second appeal to the Claims Administrator and that Your right to bring a civil action under section 502(a) of ERISA follows Your final appeal.

NOTE: If you do not comply with the Plan's claims review procedures—or do not do so in a timely manner—you will have failed to exhaust your administrative remedies and may not commence any legal or equitable action in court claiming benefits under the Plan.

END OF SECTION

LEGAL NOTICES

YOUR RIGHTS UNDER ERISA

As a participant the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE:

- Continue health care coverage for Yourself, Spouse or dependents if there is a loss of coverage under a COBRA Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this SPD and the documents governing the COBRA Plan on the rules governing Your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 Months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 Months (18 Months for late enrollees) after Your enrollment date in Your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES: In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS: If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS: If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MANDATORY VENUE:

If you wish to file a lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to this Plan, you must do so in federal court in **Dallas County, Texas**. The federal courts in **Dallas County, Texas** shall have **exclusive jurisdiction** over all disputes arising out of or in any way relating to this Plan.

REGULAR PLAN BENEFIT PROGRAM IS A "GRANDFATHERED HEALTH PLAN"

The Southwest Airlines Co. Welfare Benefit Plan believes the Regular Plan Medical Program is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that coverage under the Regular Plan Medical Program may not include certain consumer protections of the Affordable Care Act that apply to other plans such as the BenefitsPlus Medical Program, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health & Wellness Team by emailing askbenefits@wnco.com or phoning (800) 551-1211. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If a Covered Individual receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, coverage under the Plan for the following procedures and treatments will be provided in the manner determined in consultation with the attending Physician and the patient:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage of expenses for such procedures and treatment is subject to the same Deductibles, Copayments and Coinsurance limitations as are established for other benefits as described in this SPD. See the 2013 SPD for a description of such limitations.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Plan may not, under federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay no in excess of 48 hours (or 96 hours, as applicable).

CONTINUING YOUR COVERAGE THROUGH COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), if Your coverage (or the coverage of any of Your Family Members) under the Southwest Medical, Dental, Vision, and/or Health Care FSA Programs (the "COBRA Plans") ends, or is not provided under materially similar terms and conditions, due to a qualifying event, You and Your covered Family Members who are qualified beneficiaries may be eligible to purchase temporary continuation coverage through COBRA for the same health care benefits You and Your covered Family Members were covered under the day before the qualifying event (subject to changes applicable to similarly situated non-COBRA beneficiaries). COBRA continuation coverage is generally not available for Committed Partners because it is not required by federal law. However, Your Committed Partner and Your Committed Partner's children may be eligible for continuation coverage in certain circumstances. See the Partner Policy for additional information.

IMPORTANT: Please take special note of Your notification obligations which are explained on the following pages.

Except as described in the Partner Policy, the COBRA Plans do not provide for continuation coverage except as required by law. Therefore the following provisions will be construed and applied to provide continuation coverage only to the minimum extent required by law.

WHO ARE QUALIFIED BENEFICIARIES

You, Your covered Spouse, and Your covered dependent children who are covered by a COBRA Plan on the day before a "qualifying event" (as described below) are "qualified beneficiaries." A "qualified beneficiary" also includes any child who is born to or placed for adoption with You during Your COBRA coverage period.

WHEN CAN QUALIFIED BENEFICIARIES PURCHASE COBRA COVERAGE

If You are a qualified beneficiary and You lose coverage under a COBRA Plan as a result of any of the following events, these events are considered qualifying events entitling You to elect COBRA coverage:

- You terminate employment with Southwest (other than by reason of gross misconduct as determined by Southwest) or
- You have a reduction in hours worked.

If You are the covered Spouse of an Employee of Southwest, You have the independent right to elect health plan continuation coverage for Yourself and Your covered Family Members if You lose group health coverage under the COBRA Plans because of any of the following qualifying events:

- A termination of the Employee's employment (other than by reason of gross misconduct as determined by Southwest),
- A reduction in the Employee's hours of employment with Southwest,
- The death of the Employee,
- Divorce or, if applicable, legal separation from the Employee, or
- The Employee becomes entitled to Medicare benefits.

If You are the covered dependent child of an Employee of Southwest (including a child who is born to, adopted, or placed for adoption with the Employee during the period of COBRA continuation coverage), You have the independent right to elect continuation coverage for Yourself if You lose group health coverage under the COBRA Plans because of any of the following qualifying events:

- A termination of the Employee's employment (other than by reason of gross misconduct as determined by Southwest),
- A reduction in the Employee's hours of employment with Southwest,
- The death of the Employee,
- The Employee's divorce or, if applicable, legal separation from your other parent, or
- You cease to be a "dependent child" under the terms of a COBRA Plan (because of, for example, attainment of age).
- The Employee becomes entitled to Medicare benefits.

A reduction or elimination of coverage in anticipation of any of the above qualifying events is disregarded in determining whether the event results in a loss of coverage.

Rights similar to those described above may apply to covered retirees and their covered spouses and dependents who are covered by a COBRA Plan if Southwest commences a bankruptcy proceeding and such individuals lose coverage (or coverage is substantially eliminated) under a COBRA Plan within one Year before or after commencement of the bankruptcy proceeding. Additional information will be provided in the event of such a proceeding.

Note that Your covered Family Members may not independently elect COBRA continuation under the Health Care FSA Program. The right to elect continuation coverage under this program is limited to the Employee.

IMPORTANT: EMPLOYEE, SPOUSE, AND DEPENDENT NOTIFICATIONS REQUIRED

Under the law, You and Your Covered Family Members must notify the Southwest Health & Wellness Team (see contact information below) in writing of a divorce, legal separation, or a child losing dependent status under a COBRA Plan. The written notice must specify the type of qualifying event (divorce, legal separation, or child's loss of dependent status), the date of the event, and the names and Social Security numbers of the affected qualified beneficiaries. This notice must be provided within 60 days after whichever date is later:

- the date of the event or
- the date on which health plan coverage would be lost under the terms of a COBRA Plan because of the event.

Carefully read the family member eligibility and Change in Family Status rules in this SPD to understand when a family member is no longer an eligible family member under the terms of a COBRA Plan. **If the required written notice is not provided to the Health & Wellness Team within the 60-day period described above, COBRA continuation coverage will not be available.**

Southwest, rather than the Employee or other qualified beneficiary, is responsible for providing notice of other qualifying events to the Health & Wellness Team. The Health & Wellness Team, on behalf of the Plan Administrator, will then provide a COBRA election notice to eligible qualified beneficiaries as described below.

The Health & Wellness Team reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if You or a covered Family Member is determined to be ineligible or if there has been a material misrepresentation.

ELECTION OF COBRA COVERAGE

Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60-day election window is measured from the later of the date health plan coverage is lost due to the event or the date of the COBRA election notice that is provided by the Health & Wellness Team or the authorized COBRA administrator. Except as provided below with respect to certain individuals eligible for trade adjustment assistance, this is the maximum period allowed to elect COBRA, as the COBRA Plans do not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this election period (or the special election period described below), then rights to continuation coverage will end, and he or she will cease to be a qualified beneficiary.

Certain individuals eligible for trade adjustment assistance ("TAA") under the Trade Act of 1974, as amended, may also be eligible for a special COBRA election period. The TAA program is a federal entitlement program that assists U.S. workers who have lost or may lose their jobs as a result of foreign trade. Specifically, if you (1) are a "TAA-eligible individual" (as defined below), (2) had a "TAA-related loss of coverage" (as defined below), *and* (3) did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of such TAA-related loss of coverage, you may elect COBRA coverage during the 60-day period that begins on the first day of the Month in which you are determined to be a TAA-eligible individual and ends on the 60th consecutive day thereafter, as long as the election is made not later than 6 Months after the date of the TAA-related loss of coverage. **In order to exercise your right to elect COBRA coverage during this second election period, you must notify the Health & Wellness Team of your becoming a TAA-eligible individual (and provide the Health & Wellness Team with a copy of your TAA-eligibility certificate issued by a state workforce agency) prior to the expiration of the period during which such election may be made.**

A "**TAA-eligible individual**" is an "eligible TAA recipient" as defined in section 35(c)(2) of the Internal Revenue Code and an "eligible alternative TAA recipient" as defined in section 35(c)(3) of the Internal Revenue Code.

A "**TAA-related loss of coverage**" is the loss of health benefits coverage associated with a TAA-eligible individual's separation from employment that gave rise to his or her becoming a TAA-eligible individual.

Any COBRA coverage elected during this second election period for TAA coverage will begin on the first day of the second election period and will not include any prior period.

If You and/or Your spouse are qualified beneficiaries, You and/or Your spouse may elect to receive COBRA coverage on behalf of all other qualified beneficiaries with respect to a qualifying event. In addition, an election on behalf of a minor child may be made by the child's parent or legal guardian, and an election on behalf of an incapacitated or deceased qualified beneficiary may be made by the qualified beneficiary's legal representative, estate, or spouse, as applicable.

For BenefitsPlus, You and Your qualified beneficiaries, as applicable, may separately elect to continue coverage under COBRA for some or all of the Medical, Dental, and/or Vision coverage You had immediately prior to the qualifying event. For the Regular Plan, You and Your qualified beneficiaries, as applicable, cannot elect to continue Dental coverage under COBRA unless You also elect to continue Medical coverage, but can separately elect whether to continue the Vision coverage applicable immediately prior to the qualifying event.

SPECIAL CIRCUMSTANCES FOR FMLA

If You take FMLA leave, no qualifying event occurs unless You do not return to work at the end of the FMLA leave and You (or Your qualified beneficiaries) would otherwise lose coverage under the COBRA Plans before the end of the maximum COBRA continuation period. COBRA coverage will be measured from the date Your FMLA leave ends.

COBRA coverage will be offered to You and any of Your Covered Family Members who are qualified beneficiaries and were covered on the day before the first day of Your FMLA leave (or who become covered during Your FMLA leave).

If You elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the USERRA coverage will run concurrently with any COBRA coverage You elect to receive.

LENGTH OF CONTINUATION COVERAGE

If the event causing the loss of coverage is a termination of employment (other than by reason of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 Months from the date of the qualifying event.

However, if You become entitled to Medicare before your termination of employment or reduction of hours, the maximum length of COBRA coverage for any eligible qualified beneficiaries (other than You) ends on the later of (i) 36 Months from the date You become entitled to Medicare or (ii) 18 Months from the date of Your termination or reduction in hours.
If the original event causing the loss of coverage is the death of the Employee, divorce, legal separation, the Employee's entitlement to Medicare or a dependent child ceasing to be a dependent child under a COBRA Plan, then each eligible qualified beneficiary will have the opportunity to continue coverage for 36 Months from the date of the qualifying event.

If Your spouse or dependent child is a qualified beneficiary covered under COBRA due to your termination of employment or reduction in hours and a second qualifying event occurs that is a death, divorce or legal separation, Your entitlement to Medicare if it results in the loss of coverage under a COBRA plan, or a dependent child ceasing to be a dependent child under a COBRA Plan, that qualified beneficiary may receive up to a total of 36 Months of coverage.

IMPORTANT: Notification Required

If a second qualifying event occurs after Your initial qualifying event, as described in the previous paragraph, You or Your qualified beneficiary or beneficiaries must notify the COBRA Administrator (contact information below) in writing within 60 days after the second qualifying event. The written notice must specify the date it occurred, and the names and Social Security numbers of the participant and the affected qualified beneficiaries. **If the required notice is not provided within such 60-day period, the extension of COBRA continuation coverage will not be available.**

The length of Continuation Coverage for Your Health Care FSA Program will not extend beyond the end of the Plan Year in which You elect COBRA.

The length of Your continuation coverage will be extended if and to the extent required by USERRA.

TEMPORARY EXTENSION FOR TAA ELIGIBLE INDIVIDUALS

If You lose coverage on account of a reduction in your work hours or a termination of Your employment (for reasons other than gross misconduct) and are a "TAA-eligible individual" (as defined above in the "Election of COBRA Coverage" section) as of the date that the maximum period of COBRA coverage would otherwise terminate, your maximum period of COBRA coverage will not end earlier than the date you cease to be a "TAA-eligible individual" or, if earlier, February 12, 2011 (or January 1, 2014, for periods of coverage that would otherwise end on or after November 20, 2011). This temporary extension applies to COBRA coverage for which the maximum period would end on or after February 17, 2009, in the absence of this special provision.

EXTENSION IF YOU OR A COVERED FAMILY MEMBER IS DISABLED

If You or Your Covered Family Member is totally disabled, as determined by the Social Security Administration, on the date of the qualifying termination of employment or reduction in work hours or at any time during the first 60 days of COBRA coverage (or, in the case of a qualified beneficiary who is a child born to or placed for adoption with You during Your COBRA coverage period, within 60 days of the birth or placement for adoption), COBRA coverage for You and all covered Family Members may extend for an additional 11 Months beyond the 18-Month coverage period due to Your termination of employment or reduction in hours (for a total of 29 Months).

IMPORTANT: Notification Required

It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a written copy of the determination to the COBRA Administrator (contact information below) within 60 days after the date of determination (or, if the determination was made before the qualifying event, within 60 days after the later of the date of the qualifying event or the date coverage is lost as a result of such event) and before the expiration of the original 18 Months of continuation coverage. The copy of the determination should be accompanied by a written notice that includes the names and Social Security numbers of the participant and the affected qualified beneficiaries. **If the required notice is not provided within such 60-day period, the extension of COBRA continuation coverage will not be available.** The qualified beneficiary must also provide notice within 30 days if the Social Security Administration determines that the qualified beneficiary is no longer disabled.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension.

PAYMENT OF PREMIUMS

A qualified beneficiary will have to pay the entire cost of coverage plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 Months to 29 Months due to a Social Security disability, the COBRA Plans may charge up to 150% of the applicable cost of coverage during the extended coverage period as long as the disabled qualified beneficiary is included in the coverage.

A qualified beneficiary must pay the cost of continuation coverage for the period between the date of the qualifying event and the last day of the Month in which he or she elects COBRA coverage within 45 days after the date he or she elects

coverage. No grace period applies for making premium payments in this situation. Subsequent ongoing premium payments are due on the first day of each Month. A 30-day grace period for ongoing payments is provided.

Although COBRA does not require Monthly bills to be provided, the COBRA Administrator will send a bill on a Monthly basis. If You do not receive a bill, You are still required to make Your premium payment during the specified time period as described above. When making Your premium payment, write "COBRA," the Month(s) for which the payment is being made, and each COBRA participant's name and identification number in the memo portion of Your check. Payments must be sent to the COBRA Administrator (contact information below). All payments must be made via personal check, money order, or cashier's check.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. The Trade Adjustment Assistance Extension Act of 2011 increased the percentage of the health coverage tax credit ("HCTC"), effective through January 1, 2014. In January 2012, the Monthly HCTC began paying 72.5% of qualified health insurance premiums, and qualifying individuals began paying 27.5%. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

CANCELLATION OF CONTINUATION COVERAGE

COBRA continuation coverage will end prior to the maximum continuation period if any of the following events occur:

- Southwest no longer provides any group health plan to any of its Employees.
- Any required premium for continuation coverage is not paid in a timely manner.
- A qualified beneficiary becomes, after the date of COBRA election, covered under another group health plan (including coverage or entitlement to coverage under Part A or Part B of Medicare) that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary or his or her dependent, other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary or his or her dependent by reason of the Health Insurance Portability and Accountability Act of 1996.
- A qualified beneficiary extends continuation coverage to 29 Months due to a Social Security disability, the original 18-Month COBRA coverage period has ended, and a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled.
- A qualified beneficiary notifies the COBRA Administrator that they wish to cancel COBRA continuation coverage.
- Any other event that permits the termination of COBRA continuation coverage under applicable law.

NOTIFICATION OF ADDRESS CHANGE

To insure all covered individuals receive information properly and efficiently, it is important that You notify the Southwest Health & Wellness Team of any address change as soon as possible. Failure to do so could result in delayed COBRA notifications or a loss of continuation coverage options.

OTHER NOTIFICATIONS

Notifications required from You or Your qualified beneficiary under this section may be provided by You, Your qualified beneficiary, or any representative acting on behalf of either You or Your qualified beneficiary. The provision of notice by one individual satisfies the obligation to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event. Notice may be rejected if it does not identify the covered Employee and eligible qualified beneficiaries and specify the relevant events, dates, and individuals.

CONTACT INFORMATION

Should an actual qualifying event occur, and it is determined that You are eligible for COBRA, You will be notified of Your COBRA rights at that time. If any covered individual does not understand any part of this Section or has questions regarding COBRA, please contact:

Southwest Airlines Co. Health & Wellness Team
P.O. Box 36611
Dallas, Texas 75235
(800) 551-1211

Correspondence and notices to the COBRA Administrator must be sent to:

Benefit Concepts Inc.
P.O. Box 246
Barrington, Rhode Island 02806-0246
(866) 629-6447
Fax (866) 629-6390

HIPAA AND HEALTH PLAN PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

BRIEF SUMMARY

A federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") gives you privacy rights with respect to medical information held by the Southwest Airlines Co. Welfare Benefit Plan (the "Southwest Plan"). The same rules also apply to the AirTran Airways, Inc. Health and Welfare Benefit Plan (the "AirTran Plan"). For convenience, when the same rule applies to both plans, we simply refer to the "Plan" or "Plans." Under HIPAA, your HIPAA-covered health information (called "protected health information") can only be used or disclosed in certain ways. This Notice of Privacy Practices describes the rights you have under HIPAA and the rules the Plans must follow.

EFFECTIVE DATE AND SCOPE OF NOTICE

This Notice is effective as of July 1, 2013 and applies to the Southwest Plan, sponsored by Southwest Airlines Co. and its affiliates other than AirTran Airways, Inc. (the "Employer"). The Notice also applies to the AirTran Plan, maintained by the Employer's affiliate, AirTran Airways, Inc. ("AirTran"). This Notice does not apply to any entity other than the Plans. This Notice only applies with respect to the health plan components of the Plans. To the extent the Plans provide benefits other than health benefits (such as disability, life insurance, accidental death and dismemberment or severance pay), this Notice does not apply to such non-health-plan benefits.

HIPAA regulates the use and disclosure of protected health information by the Plans. This Notice is required by law and summarizes the requirements of HIPAA. It is not a contract or guarantee and does not provide any additional or other rights not expressly provided under and required by HIPAA. An individual cannot sue or bring a claim or other action against any of the Plans or any other person to enforce any of the provisions of this Notice or the requirements of HIPAA.

This Notice does not apply to health information that does not identify an individual. Such "de-identified" information is not protected health information.

PURPOSE OF NOTICE

The Plans are required by law to take reasonable steps to maintain the privacy of protected health information and to inform you about:

- The practices of the Plans regarding use and disclosure of your protected health information;
- Your privacy rights with respect to your protected health information;
- The Plans' duties with respect to your protected health information;
- Your right to file a complaint with the Plans and the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- The person or office to contact for further information about the privacy practices of the Plans.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Disclosure to You: The Plans may disclose your protected health information to you or your personal representative.

Disclosure to HHS: The Secretary of HHS may require use and disclosure of your protected health information to investigate or determine the Plans' compliance with HIPAA.

Use and Disclosure for Treatment, Payment, Health Care Operations and Plan Administration: The Plans and their business associates may use and disclose protected health information to carry out treatment, payment, and health care operations. The Plans may also use and disclose protected health information to contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. As an organized health care arrangement, the Plans may share protected health information with each other to carry out treatment, payment, or health care operations relating to the Plans. The Plans and any health insurers or HMOs with respect to the Plans may disclose protected health information to the Employer for purposes of administering the Plans. To permit such disclosure, the Employer has amended the governing documents for the Plans as required by HIPAA.

- **Treatment** is the provision, coordination, or management of health care and related services, including consultations and referrals between one or more of your Providers. For example, the Plans may disclose to a treating specialist the name of your treating Provider so that the specialist may ask for relevant medical information from your Provider.

- **Payment** includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorization). For example, a Plan may also disclose claim information relating to a Covered Family Member (including the participating Employee and the Employee's spouse) to the Employee or the Employee's spouse if the disclosure is for the Plan's payment activities.

- **Health Care Operations** include, but are not limited to, quality assessment and improvement; reviewing competence or qualifications of health care professionals; underwriting, premium rating, and other activities relating to insurance contracts; activities relating to improving health or reducing health care costs (such as wellness activities) and

coordination of care; disease management; case management; conducting or arranging for medical review; legal services and auditing functions, including fraud and abuse compliance programs; business planning and development; business management (including business acquisition activities); and general administrative activities. For example, the Plans may use or disclose your claim information to refer you to a disease management program, project future benefit costs, or audit the accuracy of the claims processing functions of the Plans.

Use and Disclosure of Summary Health Information: The Plans may use "summary health information", and disclose such information to the Employer, for purposes of obtaining premium bids or modifying, amending, or terminating the Plans (these are sometimes called "underwriting" purposes). Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by Employees and Covered Family Members and that does not include certain identifying information. The Plans may not use or disclose health information containing your genetic information if the use or disclosure is for underwriting purposes.

Use and Disclosure with Your Authorization: Uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization. For example, the Plans generally will not disclose your protected health information to the Employer for employment purposes or other non-health plan purposes without your authorization. The Plans generally may use or disclose any psychotherapy notes the Plans hold only with your authorization. You may revoke an authorization in writing unless action has been taken in reliance on such authorization. The revocation of an authorization does not apply to any disclosures already made with authorization.

Use and Disclosure to Family Members and Others: The Plans may disclose your protected health information to family members, other relatives, and your close personal friends if the information is directly relevant to the family member's, relative's, or friend's involvement with your care or payment for that care and if you are present at or prior to the disclosure and have either agreed to the disclosure or have been given an opportunity to object and not objected. If you are not present or are incapacitated or it is an emergency, the Plans will use their professional judgment to determine whether disclosing protected health information related to your care or payment is in your best interest under the circumstances.

Your protected health information remains protected by the Plans for at least 50 Years after you die. Note that the Plans may disclose to a family member, or other person involved in your health care prior to your death, the protected health information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told the Plans of your preference.

Other Permissible Uses and Disclosures: The Plans may use and disclose your protected health information without your consent, authorization, or request to the extent permitted by HIPAA, which includes uses and disclosures under the following circumstances:

- When required by federal, state, or local law.
- When permitted for purposes of public health activities. For example, protected health information may be disclosed to a public health authority for the purpose of preventing or controlling disease or injury or to report child abuse or neglect.
- When required or authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that the individual may be a victim of abuse, neglect, or domestic violence.
- For health oversight activities authorized by law. This includes uses or disclosures in civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against Providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required in the course of any judicial or administrative proceeding. For example, the Plans may disclose protected health information in response to a court order. The Plans may also disclose such information in response to a subpoena or discovery request provided certain conditions are met.
- For law enforcement purposes. For example, if required by law, the Plans may disclose protected health information to report certain types of wounds. The Plans may also disclose certain protected health information in response to a law enforcement request for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person or for certain purposes relating to the victim of a crime.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to a funeral director, consistent with applicable law, as necessary to carry out the duties of the director with respect to the decedent.
- For the purpose of facilitating organ, eye, or tissue donation and transplantation.
- For research purposes, subject to certain conditions.
- When consistent with applicable law if the Plans, in good faith, believe the use or disclosure is necessary (1) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat or (2) for law enforcement authorities to identify or apprehend an individual. The Plans may also disclose protected health information to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- For purposes of certain specialized government functions, including military and veterans activities, national security

and intelligence activities, certain protective services, and activities of correctional institutions.

- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

PRIVACY RIGHTS

Right to Request Restriction on Use and Disclosure of Protected Health Information: You may request that the Plans restrict use and disclosure of your protected health information to carry out treatment, payment, or health care operations or restrict use and disclosure to family members, relatives, or friends identified by you who are involved in your care or payment for your care. The Plans will consider the requests but generally are not required to agree to them. The Plans will agree to (and will not terminate) a restriction request if:

- The disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and
- The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

The Plans may accommodate your request to receive communications of protected health information by alternative means or at alternative locations if you notify the Plans that communication in another manner may endanger you.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information or alternative communications of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Restriction Request" c/o the Privacy Official (see the "Contact Information" section below).

Right to Inspect and Copy Your Protected Health Information: You have the right to inspect and obtain a copy of your protected health information contained in a "designated record set" for as long as the Plans maintain such protected health information. A "designated record set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plans and used to make decisions about individuals. However, certain types of protected health information will not be made available for inspection and copying, including psychotherapy notes and protected health information collected by the Plans in connection with, or in reasonable anticipation of, any claim or legal proceeding. The requested information generally will be provided within 30 days. A single 30-day extension is allowed if the Plans are unable to comply with the deadline.
Your protected health information may be maintained electronically. If so, you can request an electronic copy of your protected health information. If you do, the Plans will provide you with your protected health information in the electronic form and format you requested, if it is readily producible in such form and format. If not, the Plans will produce it in a readable electronic form and format as mutually agreed upon.

You may request that the Plans transmit your protected health information directly to another person you designate. If so, the Plans will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where the Plans should send the copy of your protected health information.

You or your personal representative will be required to complete a form to request access to your protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Inspection Request" c/o the Privacy Official (see the "Contact Information" section below). If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights, and a description of how you may complain to the Secretary of the HHS.

Right to Amend Your Protected Health Information: You have the right to request that the Plans amend your protected health information or a record about you contained in a designated record set for as long as the information is maintained in the designated record set. The Plans may deny your request if it is not in writing or does not include a reason that supports the request. In addition, the Plans may deny your request if you request to amend protected health information that is accurate and complete; was not created by the Plans, unless the person or entity that created the protected health information is no longer available to make the amendment; is not part of a designated record set kept by or for the Plans; or is not part of the protected health information which you would be permitted to inspect and copy. The Plans have 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plans are unable to comply with such deadline.

You or your personal representative will be required to complete a form to request an amendment of your records or protected health information in a designated record set. Such requests must be submitted to the attention of "Protected Health Information Amendment Request" c/o the Privacy Official (see the "Contact Information" section below). If the request is denied in whole or in part, the Plans must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of such protected health information.

Right to an Accounting of Protected Health Information Disclosures: The Plan will provide you with an accounting of the Plan's disclosures of your protected health information during the six-Year period prior to the date of your request (or the time specified by your request, if less). However, such accounting need not and will not include disclosures made: (1) to carry out treatment, payment, or health care operations; (2) to individuals about their own protected health information; (3) for certain national security purposes or law enforcement purposes; (4) as part of a limited data set; or (5) pursuant to your written authorization.

You or your personal representative will be required to complete a form to request an accounting of disclosures of your protected health information. Such requests must be submitted to the attention of "Protected Health Information Accounting" c/o the Privacy Official (see the "Contact Information" below). If the accounting cannot be provided within 60 days after your request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-Month period, the Plan will charge a reasonable, cost-based fee for each additional accounting beyond the first.

Right to a Paper Copy of this Notice: To obtain a paper copy of this Notice, submit a request to the attention of "Privacy Notice Request" c/o the Privacy Official (see the "Contact Information" section below).

Your Personal Representatives: You may exercise your rights under this Notice through a personal representative. Your personal representative may be required to produce evidence of authority to act on your behalf before the representative will be given access to your protected health information or allowed to take any action for you. Proof of such authority may include a parental relationship, a duly notarized power of attorney for health care purposes, or a court order of appointment of the representative as the conservator or guardian of the individual. The Plans retain the discretion to deny access to your protected health information to a personal representative to the extent permitted by applicable regulations.

Breach Notification: You have the right to receive notice of a breach of your unsecured protected health information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your protected health information, the notice will be provided to your next of kin or personal representatives if the Plan knows the identity and address of such individuals(s).

DUTIES OF THE PLANS

The Plans are required by HIPAA to maintain the privacy of protected health information and to provide covered Employees and Covered Family Members with this Notice of the privacy practices of the Plans.

Each Plan is required to abide by the terms of the Notice currently in effect. However, the Plans reserve the right to change their privacy practices at any time and to apply the changes to any protected health information received or maintained by the Plans prior to the date such change is adopted. If a privacy practice is changed, a revised version of this Notice will be provided to all covered Employees and Covered Family Members. Such revised Notice will be provided via hand delivery, mail, or, to the extent permissible, e-mail or electronically. The exact method of delivery will be determined by the Plans and may be different for different individuals. Any revised version of this Notice will be distributed within the time period required by law.

When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plans generally will make reasonable efforts not to use, disclose, or request more than the minimum amount of protected health information reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, this "minimum necessary" standard will not apply in the following situations: (1) disclosures to or requests by a health care Provider for treatment; (2) uses or disclosures made to the individual or a personal representative; (3) disclosures made to HHS; (4) uses or disclosures that are required by law; (5) uses or disclosures made pursuant to an authorization; and (6) uses or disclosures that are required for compliance with HIPAA regulations.

COMPLAINTS

If you believe that your privacy rights have been violated, you may complain to the Plans. To do so, please provide your complaint to: Privacy Official, Southwest Airlines Co. Welfare Benefit Plan, 2702 Love Field Drive, Dallas, Texas 75235, phone: (214) 792-6070, email: privacy.official@wnco.com. Note that this individual receives complaints for both the Southwest Plan and the AirTran Plan. You may also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F HHH Bldg., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint. An individual cannot sue or bring a claim or other action against any of the Plans or any other person to enforce any of the provisions of this Notice or the requirements of HIPAA.

CHOICE OF LAW

As a condition of participating in the Plans the Employer requires, and you agree, that your state-law-based privacy rights, if any, will be governed by the laws of the State of Texas. The prior sentence shall in no circumstance lead to the conclusion that state laws apply when they are not legally required to apply. This choice of law may be modified by the Employer. Any such modification shall apply immediately and shall supersede any prior choice of law.

CONTACT INFORMATION

If you have any questions regarding this Notice or the subjects described in it, you may contact the Privacy Official: Privacy Official, Southwest Airlines Co. Welfare Benefit Plan, 2702 Love Field Drive, Dallas, Texas 75235, phone: (214) 792-6070, email: privacy.official@wnco.com. Note that this individual serves as the contact for both the Southwest Plan and the AirTran Plan.

IMPORTANT NOTICE FROM THE PLAN ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where You can find it. This notice has information about Your current prescription drug coverage with the Southwest Airlines Co. Welfare Benefit Plan (the "Plan") and about Your options under Medicare's prescription drug coverage. This information can help You decide whether or not You want to join a Medicare drug plan. If You are considering joining, You should compare Your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in Your area. Information about where You can get help to make decisions about Your prescription drug coverage is at the end of this notice.

There are two important things You need to know about Your current coverage and Medicare's prescription drug coverage. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher Monthly premium.

The Plan has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because Your existing coverage is, Creditable Coverage, You can keep this coverage and not pay a higher premium (penalty) if You later decide to join a Medicare drug plan.

You can join a Medicare drug plan when You first become eligible for Medicare and each Year after that from October 15th through December 7th. However, if You lose Your current creditable prescription drug coverage, through no fault of Your own, You will be eligible for a two (2) Month Special Enrollment Period (SEP) because You lost creditable coverage to join a Medicare drug plan.

If You decide to join a Medicare drug plan, Your current Plan coverage will not be affected. You can keep your Plan coverage if You elect Medicare Part D, and the Plan will coordinate with part D coverage. See the Plan's SPD for more information about what happens to Your current coverage if You join a Medicare drug plan.

Your current Plan coverage pays for other health expenses in addition to prescription drugs. If You join a Medicare drug plan, You and Your eligible dependents will still be eligible to receive health benefits and prescription drug benefits under the Plan (although Your Southwest Airlines health benefits may be coordinated with any health benefits available to You under Medicare).

If You do decide to join a Medicare drug plan and drop Your current Plan coverage, be aware that You and Your dependents will not be able to get this coverage back.

You should also know that if You drop or lose Your coverage with the Plan and don't join a Medicare drug plan within 63 continuous days after Your current coverage ends, You may pay a higher premium (a penalty) to join a Medicare drug plan later.

If You go 63 continuous days or longer without prescription drug coverage (i.e., coverage that is generally at least as good as Medicare's prescription drug coverage), Your Monthly premium may go up by at least 1% of the base beneficiary premium per Month for every Month that You did not have that coverage. For example, if You go nineteen Months without creditable coverage, Your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as You have Medicare prescription drug coverage. In addition, You may have to wait until the following October to join.

For more information about this notice or Your current prescription drug coverage, you may contact the Health & Wellness Team at (800) 551-1211 for further information. NOTE: You'll get this notice each Year. You will also get it before the next period You can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time by calling the Health & Wellness Team at (800) 551-1211. Copies are also available at **www.swalife.com** under the "About Me" tab.

For more information about Your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If eligible, You'll get a copy of the handbook in the mail every Year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call Your State Health Insurance Assistance Program (see the inside back cover of Your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call (800) MEDICARE ((800) 633-4227). TTY users should call 1-877-486-2048.

If You have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY (800) 325-0778).

Keep this Creditable Coverage notice. If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this notice when You join to show whether or not You have maintained creditable coverage and therefore, whether or not You are required to pay a higher premium (a penalty).

Name of Entity/Sender:	Southwest Airlines Co. Welfare Benefit Plan
Contact—Position/Office:	Health & Wellness Team
Address:	2702 Love Field Dr., HDQ-6EB, Dallas, Texas 75235
Phone Number:	(800) 551-1211

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If You or Your children are eligible for Medicaid or CHIP and You are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If Your or Your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If You or Your dependents are already enrolled in Medicaid or CHIP and You live in a State listed below, You can contact Your State Medicaid or CHIP office to find out if premium assistance is available.

If You or Your dependents are NOT currently enrolled in Medicaid or CHIP, and You think You or any of Your dependents might be eligible for either of these programs, You can contact Your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If You qualify, You can ask the State if it has a program that might help You pay the premiums for an employer-sponsored plan.

Once it is determined that You or Your dependents are eligible for premium assistance under Medicaid or CHIP, Your employer's health plan is required to permit You and Your dependents to enroll in the plan – as long as You and Your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **You must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in Your employer plan, You can contact the Department fo Labor electronically at www.askebsa.dol.gove or by calling toll-free 1-866-444-EBSA (3272).

If You live in one of the following States, You may be eligible for assistance paying Your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact Your State for further information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP	**COLORADO – Medicaid**
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): (800) 866-3513 Medicaid Phone (Out of state): (800) 221-3943
FLORIDA – Medicaid	
Website: https://www.flmedicaidtplrecovery.com Phone: 1-877-357-3268	
GEORGIA – Medicaid	**IDAHO – Medicaid and CHIP**
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: (800) 869-1150	Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: (800) 926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: (800) 926-2588
INDIANA – Medicaid	**IOWA – Medicaid**
Website: http://www.in.gov/fssa Phone: (800) 889-9949	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kdheks.gov/hcf Phone: (800) 792-4884	Website: http://chfs.ky.gov/dms/default.htm Phone: (800) 635-2570

LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	**MAINE** – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 977-6740 tty: (800) 977-6741
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: (800) 462-1120	**MINNESOTA** – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone : (800) 657-3629
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	
MONTANA – Medicaid Website: http://medicaidProvider.hhs.mt.gov/clientpages/clientindex.shtml Phone: (800) 694-3084	**NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: (800) 383-4278
NEW HAMPSHIRE – Medicaid Website: www.dhhs.nh.gov/oii.documents/hippapp.pdf Phone: 603-271-5218	**NEW JERSEY** – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (800) 356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710
NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	
NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: (800) 992-0900	**NORTH CAROLINA** – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: (800) 755-2604	
OKLAHOMA – Medicaid & CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	**OREGON** – Medicaid and CHIP http://www.oregonhealthykids.gov http://bhcsatudeblesoregon.gov Phone: 1-877-314-5678
PENNSYLVANIA – Medicaid Website: www.dpw.state.pa.us./hipp Phone: (800) 692-7462	**RHODE ISLAND** – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820	**SOUTH DAKOTA** – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid Website: https://www.gethippiexas.com/ Phone: (800) 440-0493	**UTAH** – Medicaid & CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414
VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: (800) 250-8427	**VIRGINIA** – Medicaid and CHIP Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: (800) 432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: (800) 562-3022 ext. 15473	**WEST VIRGINIA** – Medicaid Website: http://www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: (800) 362-3002	**WYOMING** – Medicaid Website: http://www.health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, You can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

END OF SECTION

DEFINITIONS

ACTIVE WORK/ACTIVELY AT WORK: For purposes of all sections other than Eligibility and the Leave of Absence section, Active Work/Actively at Work means performing the material duties of Your Own Occupation at Your employer's usual place of business. You will also be Actively at Work if (i) You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day, or any other absence allowed by the employer, (ii) You were Actively at Work on Your last scheduled work day before the date of Your absence, (iii) You were capable of Active Work on the day before the scheduled effective date of Your insurance or increase in insurance, and (iv) any day You were not working because You gave up Your shifts, if You were active at work on the preceding work day prior to giving up Your shift. For the definition of Last Day Actively at Work for purposes of the Leave of Absence Program, see the Leave of Absence Program section of this SPD.

AD&D: Accidental Death and Dismemberment Insurance.

AIR BAG SYSTEM: An automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration.

ALCOHOL ABUSE/DEPENDENCY: The psychological or physical dependence on or addiction to alcohol.

ALLOWABLE AMOUNT: The maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular services, supply, or procedures. For additional information see Section 1 of this SPD.

ALTERNATE FACILITY: A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by Law: surgical services; Emergency Services; or rehabilitative, laboratory, diagnostic or therapeutic services. An Alternate Facility may also provide mental health or substance use disorder services on an outpatient basis or inpatient basis (for example a residential treatment facility).

AMBULATORY SURGICAL CENTER: A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full-time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area; and
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure; and
  - It provides at least one operating room and at least one post-anesthesia recovery room; and
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services; and
  - It has trained personnel and necessary equipment to handle emergency situations; and
  - It has immediate access to a blood bank or blood supplies; and
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or X-rays, an operative report, and a discharge summary.

An Ambulatory Surgical Center that is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center.

ANOTHER GROUP HEALTHCARE PLAN is defined to include: (i) group insurance; (ii) Health Maintenance Organizations (HMO); (iii) other group health plan arrangements whether insured or not;(iv) plans designed to pay a fixed dollar benefit per day while a Covered Individual is confined in a hospital or other treatment facility but which at the time of the claim allow him or her to choose an alternate benefit;(v) plans designed to pay a fixed dollar benefit per day while a Covered Individual is confined in a hospital or other treatment facility (COB applies only to that part of the daily benefit exceeding $100 per day);(vi) group plans from other hospital or medical service organizations;(vii) group practice and prepayment plans;(viii) Federal, State, or local government plans or programs; and (ix) coverage required or provided by law.

APPROPRIATE CARE: The Employee (i) has received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability (if the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty); (ii) continues to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability; and (iii) adheres to the treatment plan prescribed by the Physician, including the taking of medications.

BENEFIT WAITING PERIOD: For the purposes of the LTD Program, the Benefit Waiting Period is the length of time You must be continuously Disabled before Your LTD benefit begins.

BENEFIT(S): The payments made to or on behalf of a Covered Individual for Covered Charges.

BOARD OF TRUSTEES: The Southwest Airlines Co. Board of Trustees is the designated Plan Administrator.

BRAND-NAME: A Prescription Drug that is either (i) manufactured and marketed under a trademark or name by a specific drug manufacturer or (ii) identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

CALENDAR YEAR OR YEAR: The period of one Year that begins at 12:01 a.m. January 1 and ends at midnight the following December 31.

CASE MANAGER: A healthcare professional or counselor retained by the Claims Administrator of the Plan to provide case management and internal review services.

CERTIFICATE: An insurance certificate issued by an Insurance Carrier pursuant to a Program in the Plan.

CHANGE IN STATUS: Change in status has the meaning set forth in the General Information section of this SPD.

CHARGES/CHARGES: The term "charges/charges" means the actual billed charges; except when the Provider has contracted directly or indirectly with the Claims Administrator for a different amount. If the Provider has contracted to receive payment on a basis other than a fee-for-service amount, then "charges" will be calculated based on a fee schedule or percentage of actual billed charges, in either case as determined by the Claim Administrator. A Charge/Expense is considered incurred when the service or the supply for which it is incurred is provided.

CHARGES INCURRED: Charges are incurred when the services or the supplies for which they are incurred are provided.

CHEMICAL ABUSE/DEPENDENCY: The psychological or physical dependence on or addiction to a substance.

CLAIMS ADMINISTRATOR: One or more third party claims administrator(s) that process claims on behalf of a Plan and maintain all expertise, processes, systems and call centers necessary for such activities. The Claims Administrator(s) are fiduciaries under the Plan for initial claims determinations and appeals.

CLEARSKIES IN-NETWORK PROVIDER: A counselor contracted with the Claims Administrator of the Medical Program to provide Employee Assistance Program services and other services.

COB: See Coordination of Benefits.

COINSURANCE: Coinsurance may be a set dollar amount or a percentage of Eligible Charges for Covered Health Services.

COMMITTED PARTNER: An individual who is eligible for coverage under the Plan, as described in the General Information section of this SPD, and who is defined therein as a Committed Partner.

CONFINED IN A HOSPITAL: A person will be considered Confined in a Hospital if he or she is (i) a registered bed patient in a Hospital upon the recommendation of a Physician or (ii) partially confined for treatment of: (a) Mental Disorder; (b) Substance Use Disorder/Dependency; or (c) other related illness. To determine benefits payable, two days of being partially confined in a Hospital will be equal to one day of being confined in a Hospital.

CONSUMER PRICE INDEX (CPI-W): The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

CONTINUOUS PAY PERIOD: Continuous Pay Period as described in the Leave of Absence section of this SPD.

CONVENIENCE CARE CLINIC (MEDICAL): Convenience Care Clinics (CCCs) are health care clinics located in retail store, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventive health care services. They are sometimes called "retail clinics", "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners (NPs) or Physician assistants (PAs). Some CCCs, however, are staffed by Physicians.

COORDINATION OF BENEFITS (COB): Coordination of Benefits as described in the Important Information section of this SPD.

COPAYMENT: The dollar amount You or Your Covered Family Member is required to pay, if any, when a service is rendered or materials are purchased.

COSMETIC SURGERY OR COSMETIC PURPOSES: Surgery or other treatment directed at improving appearance and which does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Cost Effective: The least expensive equipment or service that performs the necessary function.

Course of Treatment: A planned program to correct a diagnosed dental problem or disease. A course of treatment starts when the Dentist or Physician first treats the dental problem.

Covered Charges: See Eligible Charges.

Covered Earnings: Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid. Covered Earnings will be calculated as follows: (i) for Flight Attendants it is the individual rate of pay per trip times 94; (ii) for full-time salaried Employees it is the base annual salary; (iii) for full-time hourly Employees it is the hourly rate of pay times 2,080; and (iv) for hourly part-time Employees it is the hourly rate of pay times 1,040. Covered Earnings includes contributions made through any salary reduction agreement with Employer to any Internal Revenue Code Section 25 plan for fringe benefits, any Internal Revenue Code Section 401(k), 403(b), or 457 deferred compensation agreement, executive nonqualified deferred compensation agreement, but does not include commissions, awards and bonuses, overtime pay, per diem and any extra compensation.

Covered Family Member: Your eligible dependents, Committed Partner, and Committed Partner's Children who are properly enrolled in the Plan.

Covered Health Services: Those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Illness, Injury, Mental Illness, Substance Use Disorder or their symptoms and which are described in the Covered Charges section of the Plan and not excluded under the Charges Not Covered section of such Plan (such as services which are Experimental, Investigational or Unproven).

Covered Health Services must be provided:

- When the applicable Medical and/or Dental Program is in effect;
- Prior to the effective date coverage ends as set forth in this SPD; and
- Only when the person who receives services is a Covered Individual and meets all eligibility requirements specified in the General Information section of this SPD.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
  - It is the most Cost Effective method and yields a similar outcome to other available alternatives.
  - It is a health service or supply that is described in this section, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Individual: You and/or any of Your Family Members.

Creditable Coverage: Creditable Coverage includes coverage under a group health or medical plan, health insurance (group or individual), Medicare, Medicaid, TRICARE, CHIP, Federal Employees Health Benefits Program, a public health medical plan, or any other health program subject to the Health Insurance Portability and Accountability Act (HIPAA). Creditable Coverage does not, however, include such coverage that occurs before a Significant Break in Coverage.

Custodial Services: The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Disorder Treatment or Substance Use Disorder/Dependency Treatment). Custodial Services include, but will not be limited to (i) services related to watching or protecting a person; (ii) services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and (ii) services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible: the amount You must pay for Covered Charges in a Calendar Year before the Plan will begin paying Benefits.

Dentist: The term Dentist means a person licensed to practice dentistry or oral surgery when and where services are performed. For the Medical Program, Dentist also includes a Physician operating within the scope of his/her license when he/she performs any of the dental services described in the Medical Program.

Disabled: For purposes of the LTD Program, the Employee is considered Disabled if, solely because of Injury or Sickness, the Employee is (i) unable to perform the material duties of his or her Own Occupation and (ii) unable to earn 80% or more of his or her Indexed Earnings from working in his or her Own Occupation. After Disability Benefits have been payable for 24

months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is (i) unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience and (ii) unable to earn 60% or more of his or her Indexed Earnings for BenefitsPlus or 50% or more of his or her Indexed Earnings for the Regular Plan. The Insurance Carrier will require proof of earnings and continued disability.

DURABLE MEDICAL EQUIPMENT: Durable Medical Equipment means equipment that meets all of the following: (i) It is for repeated use and is not a consumable or disposable item; (ii) it is used primarily for a medical purpose; and (iii) it is appropriate for use in the home.

ELIGIBLE CHARGES: Eligible Charges are based on either of the following (i) when Covered Health Services are received from In-Network Providers, Eligible Charges are the contracted fee(s) with that Provider or (ii) when Covered Health Services are received from non-Network Providers, unless You receive Emergency services, Eligible Charges are determined at the Claims Administrator's discretion by either (1) calculating Eligible Charges based on available data resources of competitive fees in that geographic area, or (2) applying the negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors. Eligible Charges are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies: (i) as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association; (ii) as reported by generally recognized professionals or publications; (iii) as used for Medicare; or (iv) as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

ELIGIBLE DEPENDENT CARE CHARGES: Charges for child or elder care for a dependent that is eligible for reimbursement by the Dependent Care FSA.

EMERGENCY: An emergency is defined as a serious medical condition or symptom resulting from Sickness, disease, or other Injury which arises suddenly, or suddenly gets worse, and for which (in the judgment of a reasonable person) failure to receive immediate care, generally received within 24 hours of onset, would place the Covered Individual's life in danger or could cause permanent impairment of the Covered Individual's bodily functions.

EMERGENCY SERVICES: Emergency Services are medical, surgical, Hospital, and related health care services, including ambulance service, required for a serious medical condition or symptom resulting for Injury, Sickness or Mental Illness which (i) arises suddenly, and (ii) in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Claims Administrator, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

EMPLOYEE: The Employee is the person (who is not a Family Member) on whose behalf the Plan is established. This person must be classified by Southwest as an "Employee."

EMPLOYER: Southwest Airlines Co.
ENROLL/ENROLLMENT: The completion of all forms required for coverage under the Plan and agreement to make any required contributions.

EOB: Explanation of Benefits.

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN: Care and treatment for which the Plan Administrator or its authorized Claims Administrator determines, in its sole discretion, that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indicators, regardless of whether the trial is actually subject to FDA oversight. Clinical trials include but are not limited to phase I, II, and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The Plan Administrator or its authorized Claims Administrator determines if this item 2. is true based on (i) published reports in authoritative medical literature and (ii) regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, the federal Food and Drug Administration (FDA), the Centers for Medicare and Medicaid Services (CMS), or any other appropriate technological assessment body.
3. In the case of a drug, a device, or other supply that is subject to FDA approval if (i) it does not have FDA approval, or it has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation, (ii) it has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use is a use that is (i) included and favorably recognized for treatment of the indication in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service, and The United States Pharmacopoeia Dispensing Information or (ii) established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Providers institutional review board acknowledges that the use of the service or supply is experimental, investigational, or unproven and subject to that board's approval or the proposed use is otherwise subject to review and approval by any institutional review board.